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American Academy of Otolaryngology—Head and Neck Surgery

March 2012—Vol.31 No.03

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American Academy of Otolaryngology—Head and Neck Surgery March 2012—Vol.31 No.03

OCST Is the Hot Button Issue for the Sleep Disorders Committee

As the nation grows older and more obese, out-of-center sleep testing (OCST) is keeping the Sleep Disorders Committee of the American Academy of Otolaryngology—Head and Neck Surgery up at night.

28

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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

Letters to the Editor Questions, concerns, or comments about *Bulletin* articles and other content may be addressed to the Editor via email at bulletin@entnet.org.

Article Submissions Author guidelines are online at www.entnet.org/press/bulletin/ and AAO-HNS members are encouraged to submit articles via email to bulletin@entnet.org. *Bulletin* staff will contact the author at the completion of the editorial review process for any article submitted.

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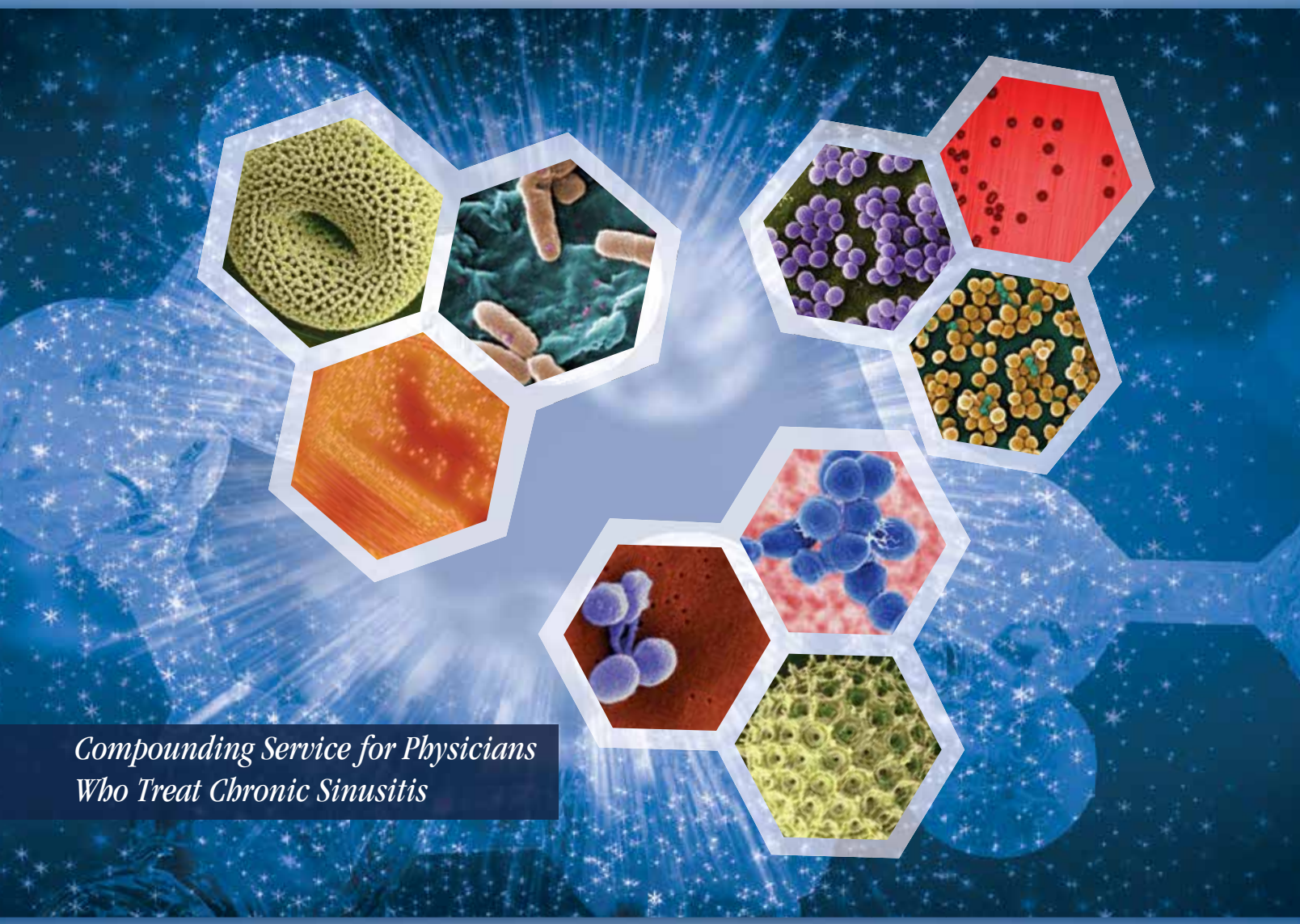

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1. Manes RP, Tong L, Batra PS.: "Prospective evaluation of aerosol delivery by a powered nasal nebulizer in the cadaver model" Int Forum Allergy Rhinol, 2011; 1:366–371
2. Yuri M. Gelfand, MD; Samer Fakhri, MD; Amber Luong, MD, PhD; Seth J. Isaacs, MD & Martin J. Citardi, MD: "A Comparative Study of the Distribution of Normal Saline Delivered by Large Particle Nebulizer vs. Large Volume/Low Pressure Squeeze Bottle" 56th Annual Meeting of the American Rhinologic Society, September 25, 2010, page 38

Power-up of Three Major Activities

Exciting things are happening this month at 1650 Diagonal Road that reflect both a powering up of planned strategic activity and an ongoing progression to deliver quality programs and services for our members.

A New Clinical Practice Guideline on Sudden Hearing Loss

A new guideline on Sudden Hearing Loss is published this month in our journal, *Otolaryngology–Head and Neck Surgery*. This represents a big commitment by this organization to Quality with a capital "Q." A multi-disciplinary panel that included representatives from multiple specialties and consumer groups developed the guideline. The AAO-HNSF strives to be at the forefront of guideline development and our methodology was highlighted frequently by the Institute of Medicine (IOM), last March, in its consensus report on trustworthy guidelines. A professional summary also appears in this issue of *Bulletin*.

Our Commitment

In Crossing the Quality Chasm: A New Health System for the 21st Century, the IOM calls on all healthcare organizations, professional groups, and private and public purchasers to adopt as their explicit purpose "to continually reduce the burden of illness, injury, and disability and to improve the health and functioning of the people of the United States." Through our vision statement, "Empowering otolaryngologist–head and neck surgeons to deliver the best ear, nose, and throat care," the Academy has indicated that delivering the highest quality healthcare to our patients is our core mission. But what does that really mean and how can the Academy support its members in providing the highest quality care in daily practice?

Your Academy is committed to bringing you the resources that you need to provide safe, effective, patient-centered, timely, efficient, and equitable care for your patients. As a specialty, we must either engage in creating and implementing clinically valid performance measures or give up our ability to influence. Evidence-based products developed by otolaryngologists for otolaryngologists will be needed for our specialty to meet the demands of payers, accrediting bodies, and maintenance of certification and licensure programs, so that our members can succeed in the changing healthcare marketplace. As otolaryngologist–head and neck surgeons, we must take the lead in defining what "quality care" means for our specialty. Your Academy's goal is to develop clinical practice guidelines and work in conjunction with national quality partner organizations to use the guidelines in development of performance measures that can apply to every practicing otolaryngologist–head and neck surgeon as quickly and efficiently as possible.

On Guidelines Development

The AAO-HNS published its first clinical practice guideline in 2006. Our guidelines are developed using an explicit and transparent methodology, which is documented in the *Clinical Practice Guideline Development Manual* (See: www.entnet.org/guidelines). Below is a list of the AAO-HNS clinical practice guidelines and a clinical consensus statement.

- Clinical practice guideline: Polysomnography for Sleep Disordered Breathing Prior to Tonsillectomy in Children - July 2011
- Clinical practice guideline: Tonsillectomy in Children - January 2011
- Clinical consensus statement: Diagnosis and Management of Nasal Valve Compromise - July 2010
- Clinical practice guideline: Hoarseness (Dysphonia) - September 2009
- Clinical practice guideline: Benign Paroxysmal Positional Vertigo (BPPV) - November 2008
- Clinical practice guideline: Cerumen Impaction - September 2008
- Clinical practice guideline: Adult Sinusitis - September 2007
- Clinical practice guideline: Acute Otitis Externa - April 2006

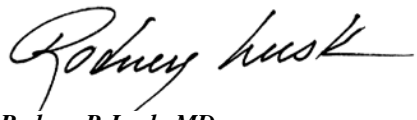
World Voice Day, April 16

Other important AAO-HNS/F activities include information for members and resources to promote World Voice Day (WVD), April 16. WVD is a health observance day advocated across the globe by physician specialists who treat medical disorders that affect voice quality, and allied health providers who teach voice preservation and rehabilitation for damaged voices. The resources, available to members when they login, include a template press release to send to health reporters with media in your community and several fact sheets that were developed this year, as well as a website banner and a small poster in this issue.

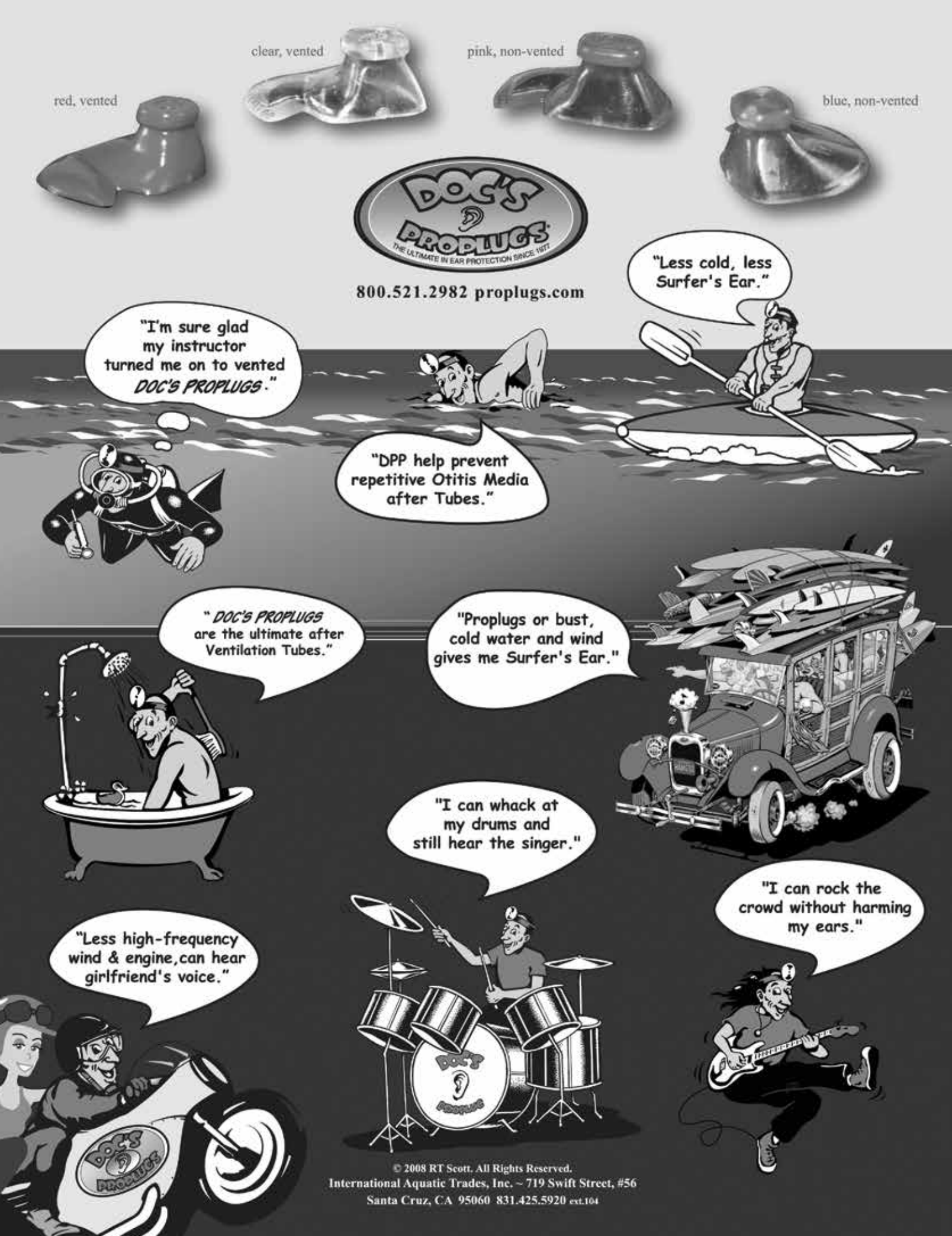
Every April 16, otolaryngologist–head and neck surgeons and other voice health professionals worldwide join together to recognize WVD. The observance encourages men and women, young and old, to assess their vocal health and take action to improve or maintain good voice habits. The American Academy of Otolaryngology—Head and Neck Surgery has sponsored the U.S. observance of World Voice Day since its inception in 2002.

Focusing on Sleep Disorders

Awareness of the serious nature of sleep disorders has become more apparent as a health concern and more diagnostic and treatment options are available. While otolaryngologists are uniquely trained to treat sleep problems, the pathway to effective treatment can be difficult for consumers to find and members to convey. At this year's Annual Meeting & OTO EXPO, the basic and translational research mini-program will focus on sleep apnea, from bench to bedside and beyond. See article on page 28 for more information.



Rodney P. Lusk, MD
AAO-HNS/F President



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The Power of Intention

David R. Nielsen MD

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

Almost all of us have had the experience of asking, "Why?" only to hear, "Because that's the way we always do it!" or, "Because I said so!" As surgeons we are trained to dislike unwanted variation. We would prefer to have our own operating room team, not a new scrub tech, charge nurse, and anesthesiologist every time we operate. We get our best results when we establish best practices and stick to them.

But as we grow, improve, and change we must balance the desire for "sameness" with the need to critically evaluate what we do, and institute improvements when needed. Much of our technology, advanced techniques, and new knowledge come from a direct and systematic approach in search of improvement. When we appropriately question what we do and how we do it, and make genuine curiosity an integral part of our professional and personal development, we not only find answers along the path, but we often stumble across positive, unexpected, and serendipitous discoveries. Our world is filled with examples ranging from Post-it® notes to Penicillin; or from Columbus' discovery of America to Rosen's discovery of stapes mobilization.

The very word, "serendipity," has a fascinating origin. It is ascribed to Horace Walpole in 1754 and based on a 16th century Persian fable called "The Three Princes of Serendip" (http://livingheritage.org/three_princes.htm). As the story goes, long ago in the country of Serendippo there lived a great and powerful king with three sons. His doubts about their fitness for succeeding him lead him to send them abroad for experience. The fable relates how these three sagacious sons trace clues to identify precisely a camel they have never seen. When they later encounter the merchant who has lost the camel, he accuses them of stealing it. When asked how they are able to give such an accurate description of the camel if they have never seen it, it becomes clear that they have cleverly used small clues to discover the nature of the camel. The missing camel is found wandering in the desert, and the Three Princes are given rich rewards. The princes continue to display their powers of observation and wisdom, and it has a happy ending. You should read the story!

According to Walpole, the process of serendipity was that "*…They were always making discoveries, by accident and sagacity, of things they were not in quest of.*" Another point of the story is to highlight the wisdom of the king, the father of the princes, who knew that in order for his sons to grow and learn, they needed to be put in a position to use their knowledge in new ways, explore new territory, and meet new people. We use the word differently today to imply chance or fate, but its original meaning was their discovery of things they were not in search of by systematically using their own wisdom and knowledge.

We as highly educated scientists and physicians should understand the critical need to be constantly using our sagacity and knowledge to examine, explore, and search. Each of us can indubitably relate an experience where we discovered something positive that we were not expecting, because we were searching, inquiring, and curious. The challenge for us is to be continuously and intentionally evaluating what we do and why we do it.

In the past few years we have experienced some very positive changes to our volunteer membership structure and staff in Research and Quality, Education, Health Policy, *Bulletin*, journal, and development activity. You will see some additional recommended improvements for the Academy in the coming year. While these changes have brought expected results, there have been many positive, unexpected benefits in member engagement, satisfaction, sustainability, and unity.

Your dedicated staff at 1650 Diagonal Road in Alexandria has adopted the attitude that we will be more evidence-based and data-driven in our decisions and work on your behalf. When the question arises about why we do things a certain way we no longer just say, "Because that's the way it's always been done." We examine the rationale behind our policies, governance, structure, and business practices to ensure that what we do and why we do it still makes sense. There is nothing wrong with doing things traditionally, or staying with tried and true methods and policies. But we should do them because we have considered the alternatives, examined the options, and can confirm that the traditional policy is superior. We should not adopt the usual methods just because we are too lazy, fearful, or busy to consider improving. We applaud you, our valued members and colleagues, for your continued creativity and inventiveness, and we join you with assurance that our intentional pursuit of excellence will be rewarded.

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Spring Showers Bring Bouquets of Health Resources

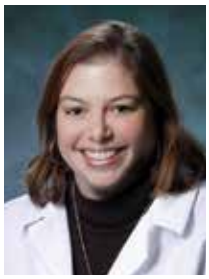
Stacey L. Ishman, MD
AAO-HNS BOG Executive Committee
Baltimore, MD

Spring showers bring May flowers—and the observance of World Voice Day, Better Sleep Month (May), and National Asthma and Allergy Awareness Month (May). Spring also is a good time to review the resources the AAO-HNS developed to help promote our practices, our specialty, and the education of our patients.

While otolaryngology–head and neck surgery is not a large specialty, we all know that the influence of our care and the breadth of our expertise contribute greatly to improving quality of life for our patients and our society. From resolution of voice problems and nasal obstruction to improvement of hearing impairment and treatment of sleep disorders, we are able to improve the lives of our patients in profound ways. Unfortunately, being fantastic clinicians and providing great care are not enough these days as competition for resources increases. However, the education of our patients and the public is a great way to focus on strategies for wellness, such as getting adequate sleep and using good vocal hygiene.

As you may know, the AAO-HNS develops fact sheets and press releases to accompany the monthly themes and topics that we highlight. These are available for free to all members on the AAO-HNS website, under the health information tab (www.entnet.org/healthinformation). Topics include thyroid disorders and surgery, flu and allergy, back to school health issues information and KIDS ENT health, the dangers of tobacco, earwax and hearing aid information, facial plastic surgery, and World Voice Day. These resources can be used to provide individual education in our offices, as a basis for a press release, or as resources for newsletters, or hospital communications.

The AAO-HNS also recently became a member of the National Sleep Awareness Roundtable (NSART). The organization's



Stacey L. Ishman, MD

goal is to educate the public on the importance of sleep to their health and safety, promote recognition of sleep health, and ensure that sleep health is optimized as new public and private sleep initiatives are created. Membership includes a number of national specialty organizations including the National Sleep Foundation (NSF), the American Academy of Pediatrics, and the American Thoracic Society, in addition to a group of government stakeholders that includes active participants from the Centers for Disease Control and Prevention, the National Institutes of Health, and its Office of the Surgeon General.

The NSF will conduct its annual National Sleep Awareness Week™ March 5-11. The week is designed to provide education via dual tracks to primary practitioners and the public to promote the importance of sleep. See the feature in this issue on page 26. During the same week, the National Sleep Foundation's Sleep in America poll results will be announced on the NSF website. These serve as a great resource for the media and provide educational content regarding current sleep practices.

In addition, April marks the 12th year that we celebrate World Voice Day to promote awareness, recognition, and celebration of the human voice. While several states have passed legislation to officially recognize April 16 as World Voice Day, most states do not have resolutions. If you are interested in finding a sponsor in your state or in promoting World Voice Day, sample sponsor letters, draft resolutions, and sample press releases are available from the AAO-HNS, www.entnet.org/community/outreach.cfm.

While the education of our patients and local media is important, May will also bring us the opportunity to meet with fellow otolaryngologists and educate our congressional representatives as the AAO-HNS sponsors the OTO Advocacy Summit. Unlike previous years, we will meet as a single specialty and be able to focus our time in advocacy training and with our legislators on our specific otolaryngology issues. This opportunity will allow for dissemination of otolaryngology-specific information. Please join us for the Board or Governors Spring Meeting May 6-7, and for the AAO-HNS OTO Advocacy Summit on May 7-8. Register at www.entnet.org/BOG&Summit.

WVD 2012 Resources

March *Bulletin* article, "Make Your Voice Count, April 16, 2012"

- History of World Voice Day
- WVD Fact Sheet
- Voice Disorders and the Workplace
- Member Template Press Release
- Academy World Voice Day Press Release

Voice Fact Sheets:

- Fact Sheet: About Your Voice
- Fact Sheet: The Voice and Aging
- Fact Sheet: Special Care for Voice Users
- Fact Sheet: Common Problems that can Affect Your Voice
- Fact Sheet: Effects of Medication on Voice
- Fact Sheet: Keeping Your Voice Healthy
- Fact Sheet: Special Care for Voice Users
- Fact Sheet: Hoarseness
- Fact Sheet: Tips for Healthy Voices

How Is Your Voice?

- Rate Your Voice
- Identify Common Vocal Health Problems
- Vocal Warm Up - 1

Promote World Voice Day!

- Podcast - World Voice Day
- Radio PSA - "It Needs To Be Said Outloud"
- UIC Video for WVD - H. Steven Sims, MD, Director of the Chicago Institute for Voice Care speaks on the importance of WVD and voice care.
- Sample legislation and sponsor letters

Join the World in Celebrating the Voice!

http://www.entnet.org/HealthInformation/worldVoiceDay.cfm

Tobacco Industry Manipulated Otolaryngology to Calm Fears Surrounding Smoking Dangers

Robert K. Jackler, MD
Chair AAO-HNS Hearing Committee and Member Otolaryngology Historical Society, Stanford, CA

Editor's note: Although this article painfully points to a troubling chapter in our specialty's history, the concerns regarding the role of participating physicians is warranted. This article reminds us that while today's emphasis on institutional transparency may seem to encroach on our perceived "freedoms" from time to time, it is based in experience—one that we as otolaryngologists swear, with each Hippocratic oath taken, will never be repeated. We thank the Otolaryngology Historical Society for its perseverance in bringing this reminder to the fore.

Starting in the early part of the 20th century, the tobacco industry became increasingly focused upon countering the emerging threat to its business posed by rising customer concerns about the adverse health consequences of smoking.

This led the industry to undertake a multifaceted and highly effective campaign to reassure smokers about the healthfulness of tobacco use. Because the public was especially concerned about "throat irritation" the support of "throat specialists" was especially sought after.

Recently, many millions of internal tobacco industry documents have become available online. Through this resource, we were able to shed light on the remarkably pervasive extent to which our specialty was manipulated into supporting the marketing of cigarettes as well as to assist the industry in avoiding legal liability and escaping regulatory limitations.

The industry adopted a wide variety of health reassurance slogans such as "Philip Morris is less irritating" and "Not One Single Case of Throat Irritation with Camels." To bolster their slogans and defend against government efforts to rein them in, companies sought out otolaryngologists willing to conduct studies with preordained results in support of their marketing slogans though it cannot be determined from the evidence available whether the otolaryngologists purposefully sought to satisfy their benefactors or whether they were unwittingly manipulated.

These pseudoscientific investigations invariably either found tobacco harmless or upheld the greater safety of the sponsor's brand. The resulting advertisements frequently appeared in otolaryngology journals such as *Laryngoscope* and *Archives of Otolaryngology.* Their copy went so far as to ask physicians to prescribe cigarettes for their patients with sore throats.

Under tobacco industry sponsorship, a virtual Who's Who of leading otolaryngologists, including department chairs and leaders of otolaryngologic organizations, prominently expressed opinions that denied the role of smoking in head and neck cancer. This involved not only court testimony in lawsuits regarding causation of laryngeal cancer, but also much higher impact forums such as testimony before the Federal Trade Commission and Congress.

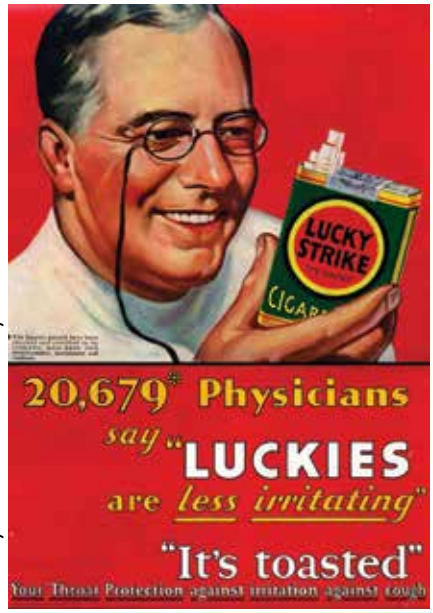
In one especially telling example, four chairs of leading otolaryngology departments, under well-compensated industry sponsorship, testified before Congress in opposition to the 1964 Surgeon General's Report that affirmed a causative relationship between smoking and cancer of the larynx.

Industry detail men visited the offices of otolaryngologists around the country and gave them free cigarettes to dispense to their patients with the recommendation that they would be better for their throats. Elegant dinners were held for otolaryngologists in many cities, at which pseudoscientific pep talks were given about the supposed reduced irritation with the company's brand.

For many years major cigarette companies hosted "Hospitality booths" at the annual meeting of the American Academy of Ophthalmology and Otolaryngology. Free cigarettes were handed out to all who registered, with the doctor's name imprinted on the pack.

The advance of our field requires close collaboration between otolaryngologists and industry. As physicians, we must

Courtesy of Stamford University



Courtesy of Stamford University

always act on behalf of the well being of our patients. We should strive to partner with industries that balance the need to maximize profits with a commitment to optimize the health of their consumers.

Reference:

1. Jackler RK, Samjii HA. The Price Paid: Manipulation of Otolaryngologists by the Tobacco Industry to Obfuscate the Emerging Truth That Smoking Causes Cancer. Laryngoscope 122:75–87, 2012.

This article is based on the paper presented at the Otolaryngology Historical Society meeting, September 12, 2011. If you are interested in presenting at the 2012 OHS meeting, September 10, in Washington, DC, or wish to join or renew as an OHS member, contact museum@entnet.org.

Correction

February's *Bulletin*, article on page 20 in the print edition, "Update on Choking Hazards and Dangers of Ingesting Lithium Batteries in Children," incorrectly stated that numerous policy statements on choking hazards were attributed to the American Academy of Pediatrics. It should have said numerous policy statements on choking hazards were developed and distributed by the **American Society of Pediatric Otolaryngologist**s (ASPO).

Dates to Remember

March (late) Acceptances sent for AAO-HNSF 2012 Annual Meeting miniseminars and instruction courses.

April *Bulletin* features the Washington DC AAO-HNSF Annual Meeting & OTO EXPO.

April 12 Notification: acceptances sent for oral and poster scientific presentations for 2012 AAO-HNSF Annual Meeting & OTO EXPO Call for Papers.

April 12-15 ENT for the PA-C Westin Arlington Gateway Hotel, Arlington, VA.

April 15 International Travel Grant application deadline: international@entnet.org.

April 16 Millenium Society Early Housing and Registration for Annual Meeting Opens.

April 16 World Voice Day.

April 22-28 OHANCAW (Oral Head and Neck Cancer Awareness Week) (see January 2012 *Bulletin*).

April 27-28 AAO-HNSF Coding & Reimbursement Workshop, Chicago, IL.

April (late) Acceptances sent for AAO-HNSF 2012 Annual Meeting orals and poster presentations.

May 6-8 BOG Spring Meeting and OTO Advocacy Summit.

May 7 General Registration opens for 2012 AAO-HNSF Annual Meeting & OTO EXPO.

June 1 Proposed 2012-2013 Combined Budget presented in the *Bulletin*.

June 1 Monthly mini PR and media outreach tools available for members.

June 22 Register now for the 2012 AAO-HNSF Annual Meeting & OTO EXPO and save with early registration discount.

APRIL 2012

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AAO-HNSF Collaborates on Physician Assistant Education

With the goal of improving patient care by providing resources that allow physician assistants (PAs) and otolaryngologist–head and neck surgeons to work together, the AAO-HNSF has been collaborating with the American Academy of Physician Assistants (AAPA) and the Society of Physician Assistants in Otorhinolaryngology / Head & Neck Surgery (SPAO-HNS). All are working together to determine ways to share resources and educate their members who are using AAO-HNSF resources.

Each organization understands and recognizes that educating PAs in the practice of otolaryngology–head and neck surgery will increase their value to Foundation members while educating them on the benefits PAs bring to their practices. It is also hoped that, through increased awareness, the number of otolaryngology positions available to graduating PAs will increase.

"As stated in our strategic plan, the Foundation is committed to enhancing the quality of patient care by expanding the knowledge base of anyone who uses otolaryngology content, including allied healthcare professionals," said **David R. Nielsen, MD**, executive vice president and CEO of AAO-HNSF. "Our partnership with AAPA and SPAO-HNS is a great example of how we can provide quality education opportunities to such a valuable audience."

One successful outcome of this project has been Clinical Otolaryngology Online (COOL). COOL is a free, peer-reviewed case study series that leads the learner from patient presentation through diagnosis, treatment, and referral. As part of the partnership, these courses are approved for AAPA Category 1 CME credit.

COOL is an excellent instructive program for health professionals who regularly encounter otolaryngology-related problems. Written by leading experts in otolaryngology, COOL cases are interactive patient scenarios that make use of e-learning technology to prepare the learner for a variety of common otolaryngologic situations. COOL is an engaging learning experience for physician assistants, nurse practitioners, primary care providers, medical students, and other health professionals. To date, there have been 2,000 completions of more than 30 COOL courses.

A second significant endeavor in this partnership is the ENT for the PA-C conference. The first successfully took place in February 2011 and the second is scheduled for April 2012 in Arlington, VA. The conference is an engaging education opportunity focused on diseases and disorders of the ear, nose, and throat. The conference is cosponsored by the three partners. It brings top faculty from across the nation to give attendees a clinical rundown on some of the most frequently encountered ENT diseases and disorders.

Course directors for 2012 include Foundation leaders **Ashutosh Kacker, MD, Karen Pitman, MD,** and **Marie Gilbert, PA-C**. Course faculty includes more than 20 physicians and physician assistant experts from AAO-HNS, AAPA, and SPAO-HNS.

"As a physician shortage looms, physician assistants have taken on a prominent role," said Dr. Kacker of Weill Cornell Medical Center. "This course is very important as it helps PAs improve their knowledge and skill levels, and it provides a platform to interact with otolaryngology–head and neck surgery experts." For 2012, lectures will be a mix of general and advanced courses with panel discussions and case reviews. Basic and advanced scope sessions will be offered, as well as procedures workshops on otoscopy, epistaxis control, and tracheostomy care. Participants will have ample time to interact with the faculty and network with colleagues. To learn more about this year's conference visit www.aapa.org/ent.

"As a leading provider of educational support for PAs and a champion of patient-centered care, AAPA is dedicated to working with our partner AAO-HNSF to provide practical and valuable educational activities for PAs, to improve patient outcomes, and drive healthcare transformation," said Mike Saxton, MEd, senior vice president and chief learning officer, AAPA. "With two successful collaborative programs, COOL and ENT for the PA-C, AAPA is excited to enhance our partnership with AAO-HNSF to provide dynamic individualized educational resources and push our programs to new heights."

The Foundation looks forward to its continued collaboration with AAPA and SPAO-HNS and to developing other successful partnerships to continue to reach new audiences and develop new resources.

Comments from 2011 ENT for the PA-C conference attendees

"Long overdue conference! Would have been a godsend when I started in ENT care, but it is still of significant value."

"Extremely well arranged conference in excellent location for a very affordable price."

"Impressive ... and greatly appreciated."

"Well done. Topical, friendly, and collegial atmosphere."

"... excellent course with lots of pearls that only come with experience ..."

"This was very well done. The topic breakdown was great. Some of the material was review and other parts filled in a few gaps and tied it up for me."

"Best course in 10 years! Great review. Takes even a seasoned PA to think basics. Great job SPAO, AAPA, and AAO-HNS!"

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Clinical Practice Guideline: Sudden Hearing Loss Summary

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The AAO-HNSF Guideline Development Task Force supported the development of the new clinical practice guideline on Sudden Hearing Loss that will be published as a supplement in the March edition of *Otolaryngology–Head and Neck Surgery*. This issue with the supplement can be viewed online at www.otojournal.org.

This following summary of "talking points" for physicians is purposely written in plain language that oversimplifies the guideline findings. The intent of this offering is to alert members to the availability of this new multidisciplinary clinical practice guideline so that the complexities of the problem and its treatment can be fully described and understood. The summary gives you an introduction to the topic, the purpose behind the guideline, and highlights the key action statements with related evidence profiles.

Talking Points Executive Summary

Clinical Practice Guideline: Sudden Hearing Loss

Sudden Hearing Loss (SHL) is a frightening symptom that often prompts an urgent or emergent visit to a physician. This guideline focuses on sudden sensorineural hearing loss (SSNHL), one of many causes of SHL, which, if recognized and managed promptly, may improve hearing recovery and patient quality of life (QOL). SSNHL affects five to 20 people per 100,000 populations, with about 4,000 new cases per year in the United States (U.S.).[1,2] Throughout this guideline the following definitions are used:

- SHL is defined as a rapid-onset, occurring during a 72-hour period, of a subjective sensation of hearing impairment in one or both ears.
- SSNHL is a subset of SHL that is a) sensorineural in nature and b) meets certain audiometric criteria.
  a. Sensorineural hearing loss (SNHL) indicates an abnormality of the cochlea, auditory nerve, or higher aspects of central auditory perception or processing.
  b. The most frequently used audiometric criterion is a decrease in hearing of greater than or equal to 30 decibels, affecting at least three consecutive frequencies. Because premorbid audiometry is generally unavailable, hearing loss is defined as related to the opposite ear's thresholds.
- Idiopathic sudden sensorineural hearing loss (ISSNHL) is defined as SSNHL with no identifiable cause despite adequate investigation.

The SSNHL definition used throughout this guideline is based on its consistent use in the literature and National Institute on Deafness and Other Communication Disorders (NIDCD) criteria; [3] however, the panel recognizes that in clinical practice, expanding the definition to cases with less than 30 decibels of hearing loss may be considered. The panel recognizes that the NIDCD definition is not universally used and, accordingly, published evidence not using this definition was considered.

The distinction between SSNHL and other causes of SHL is one that should be made by the initial treating healthcare provider, so that early diagnosis and management can be instituted. Moreover, non-idiopathic causes of SSNHL must be identified and addressed during the course of management; the most pressing of these are vestibular schwannoma (acoustic neuroma), stroke, and malignancy.[4] Up to 90 percent of SSNHL, however, is idiopathic at presentation, and is presumptively attributed to either vascular, viral, or multiple etiologies.[5]

A maximum of 32 percent to 65 percent of cases of SSNHL may recover spontaneously. [2,6] Clinical experience indicates that even this recovery rate may be an overestimation. Prognosis for recovery is dependent on a number of factors, including patient age, presence of vertigo at onset, degree of hearing loss, audiometric configuration, and time between onset of hearing loss and treatment.[7-9] Treatment options are myriad and include systemic and topical steroids, antiviral agents, rheologic agents, diuretics, hyperbaric oxygen treatment, other medications, middle ear surgery for fistula repair, and observation alone. The comparative efficacy of these treatments, however, is not known, considering that the definitive etiology is also commonly not known.

Long-term follow-up is recommended as some patients will have an underlying cause identified that may not be evident at initial presentation.[10] Additionally, the patient with partial or no hearing recovery, or persistent tinnitus, will require ongoing management from otolaryngological, audiological, and psychological perspectives.[11]

This guideline is intended for all clinicians who diagnose or manage adult patients (18 and older) who present with SHL. After addressing causes, diagnosis, and treatments of non-SSNHL briefly, this guideline will go on to address SSNHL in detail. Important points to keep in mind include:

- A cause for SSNHL is identified in only 10 percent to 15 percent of patients at the time of presentation.[7,9] Emergency intervention may be needed for rare, life-threatening conditions of which SSNHL is a part. In up to a third of cases, the cause may be identified only after long-term follow-up evaluations.[10]

- In 85 percent to 90 percent of cases, in spite of thorough evaluation, the underlying cause is unknown or uncertain at the time of presentation, and treatment decisions are generally made without knowledge of the etiology.[7,9] It is appropriate, therefore, to approach these idiopathic cases in a common way, understanding that the underlying etiologies may be dissimilar.[12]
- The primary presenting symptom of SHL is a full or blocked ear. Since this is such a common and non-specific symptom, both patients and physicians are not sufficiently frightened or worried by it. Thus, evaluation and treatment are often delayed. New onset of ear blockage or fullness can be a symptom of potentially serious conditions and warrants prompt evaluation.
- Conversely, the patient with SHL may be frightened; the nearly universal accompanying tinnitus seen in SSNHL will frequently contribute intensely to the patient's anxiety and depression.[13] All members of the hearing healthcare team should be cognizant of the psychological response to the sudden loss of a primary sense.
- Familiarity with hearing aids, hearing assistive technology (HAT), tinnitus management, and implantable hearing solutions is required in the ongoing management of these patients.
- A "team approach" to the overall management of these patients is encouraged.

The incidence of this symptom, the debilitating consequences of missed early diagnosis and management, the presentation of the patient to a variety of healthcare providers, the abundance of small series and case reports regarding treatment, and the paucity of randomized controlled trials (RCTs) assessing interventions, create a pressing need for evidence-based guidelines to aid clinicians in managing SSNHL. Moreover, wide variations in evaluation, treatment, counseling, and follow-up of patients with SSNHL exist worldwide. Such variations are usually ascribed to heterogeneity in clinical practice and training rather than to differences in clinical need. The current lack of consensus, both in the United States and worldwide, on all aspects of the care of the patient with SSNHL, further supports the need for an evidence-based clinical practice guideline to highlight best practices.

Purpose

The purpose of this guideline is to provide clinicians with evidence-based recommendations in evaluating patients with SHL, with particular emphasis on managing SSNHL. The guideline is intended for all clinicians who see adult patients, aged 18 and older. The recommendations outlined in this guideline are not intended to represent the standard of care for patient management, nor are the recommendations intended to limit treatment or care provided to individual patients. The guideline is not intended to replace individualized patient care or clinical judgment.

Although the guideline focuses primarily on managing SSNHL, the panel recognized that patients enter the healthcare system with SHL as a non-specific, primary complaint. Therefore, the initial recommendations of the guideline deal with efficiently distinguishing SSNHL from other causes of SHL at the time of presentation. The purpose of the guideline is not to present an exhaustive approach to managing SHL, in general, as only a limited number of causes are discussed.

This is the first clinical guideline on SSNHL developed in the United States. Use of this guideline may improve the care of patients and result in improved outcomes. Despite numerous published articles on SSNHL, there remains a paucity of high-quality evidence, creating confusion and practice variations in management. This guideline will provide evidence-based recommendations for clinicians based on multidisciplinary consensus and careful consideration of the benefits versus harms of suggested actions. By focusing on opportunities for quality improvement the guideline should improve diagnostic accuracy, facilitate prompt intervention, decrease inappropriate variations in management, reduce unnecessary tests and imaging procedures, and improve hearing and

rehabilitative outcomes for affected patients.

STATEMENT 1. EXCLUSION OF CONDUCTIVE HEARING LOSS:

Clinicians should distinguish sensorineural hearing loss (SNHL) from conductive hearing loss (CHL) in a patient presenting with sudden hearing loss. *Strong recommendation based on evidence with a preponderance of benefit over harm.*

Action Statement Profile for Statement 1:

- **Aggregate Evidence Quality:** Grade B, based on evidence that a common cause of CHL, cerumen impaction, can be treated effectively to improve hearing. Grade C, for evidence that CHL and SNHL can be distinguished from history, examination, and tuning fork tests.
- **Benefit:** Guide the choice of appropriate diagnostic tests, identify patients with more serious underlying conditions, avoid misdiagnosis, improve diagnostic accuracy, ensure treatment is consistent with diagnosis, guide patient expectations, identify conductive hearing loss that can be treated and resolved.
- **Risk, Harm, Cost:** Adverse effects of cerumen removal, if required; time required for cerumen removal, if required; misdiagnosis.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** Panel consensus that despite a lack of systematic research evidence supporting this action, distinguishing these types of hearing loss was an essential first step in determining subsequent management.
- **Intentional Vagueness:** The panel intentionally decided not to specify the time frame to distinguish CHL from SNHL due to inconclusive evidence of the importance of early intervention, but agreed that the distinction should be made as promptly as possible to allow intervention if a diagnosis of SSNHL is confirmed. Ideally the determination should be made at the time of initial presentation.
- **Role of Patient Preferences:** No role.
- **Exclusions:** None.
- **Policy Level:** Strong recommendation.

STATEMENT 2. MODIFYING FACTORS:

Clinicians should assess patients with presumptive sudden sensorineural hearing loss for bilateral sudden hearing loss, recurrent episodes of sudden hearing loss, or focal neurologic findings. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile for Statement 2:

- **Aggregate Evidence Quality:** Grade C, observational studies and case series
- **Benefit:** Identification of patients with a high likelihood of alternative and potentially serious underlying cause, who require specialized assessment and management.
- **Risk, Harm, Cost:** None.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** None.
- **Intentional Vagueness:** None.
- **Role of Patient Preferences:** Limited.
- **Exclusions:** None.
- **Policy Level:** Recommendation.

STATEMENT 3. COMPUTED TOMOGRAPHY:

Clinicians should not order computerized tomography of the head/brain in the initial evaluation of a patient with presumptive SSNHL. *Strong recommendation against based on systematic reviews with a preponderance of benefit over harm for not obtaining CT.*

Action Statement Profile for Statement 3:

- **Aggregate Evidence Quality:** Grade B, systematic reviews and appropriateness criteria from the American College of Radiology (ACR), plus observational studies clearly documenting the potential harms of radiation and side effects of intravenous contrast.
- **Benefit:** Avoidance of radiation, cost savings, reduced incidental findings, less inconvenience for the patient, avoiding false sense of security from false negative scan.
- **Risk, Harm, Cost:** None.
- **Benefit-Harm Assessment:** Preponderance of benefit over harm.
- **Value Judgments:** None.
- **Intentional Vagueness:** The panel recognizes that the terms "initial evaluation" are vague, but the intent is to discourage the routine use of CT scanning of the head/brain when patients initially present with SSNHL.
- **Role of Patient Preferences:** Very limited.
- **Exclusions:** Patients with focal neurologic findings.
- **Policy Level:** Strong recommendation against.

STATEMENT 4. AUDIOMETRIC CONFIRMATION OF ISSNHL:

Clinicians should diagnose presumptive ISSNHL if audiometry confirms a 30-dB hearing loss at three consecutive frequencies AND an underlying condition cannot be identified by history and physical examination. *Recommendation based on randomized controlled trials with a preponderance of benefit over harm.*

Action Statement Profile for Statement 4:

- **Aggregate Evidence Quality:** Grade C, based on criteria used in RCTs assessing the benefits for intervention for SSNHL.
- **Benefit:** Guiding treatment, identifying urgent conditions that require prompt management, ensuring that interventions for ISSNHL are limited to those patients who meet appropriate audiometric criteria for diagnosis.
- **Risk, Harm, Cost:** Potential delay in treatment until audiometry is obtained; direct cost of audiometry.
- **Benefit-Harm Assessment:** Preponderance of benefit over harm.
- **Value Judgments:** While there is limited evidence as to the audiometric cut points for definition of SSNHL, this definition has been used widely.
- **Intentional Vagueness:** None.
- **Role of Patient Preferences:** None.
- **Exclusions:** When audiometry is not available, clinical judgment should be used, based on history, examination, and tuning fork evaluation. Lack of audiometry should not preclude

discussion of, and initiation of, treatment.
- **Policy Level:** Recommendation.

STATEMENT 5. LABORATORY TESTING:

Clinicians should not obtain routine laboratory tests in patients with ISSNHL. *Strong recommendation against based on large cross-sectional studies showing a preponderance of benefit over harm.*

Action Statement Profile for Statement 5:

- **Aggregate Evidence Quality:** Grade B, based on small cross-sectional studies showing no benefit as well as case series.
- **Benefit:** Cost containment, avoidance of stress and anxiety of patient, avoidance of false positives, avoidance of delay of diagnosis, avoidance of delayed treatment.
- **Risk, Harm, Cost:** Missed diagnosis.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** Minimizing testing and the risks of false positives outweigh the value of finding a potential cause, especially when it has not been shown that early treatment affects prognosis.
- **Intentional Vagueness:** The word "routine" was to discourage a non-targeted approach to use of laboratory assessment. It is recognized that specific laboratory tests may be useful in assessing these patients based on specific individual patient conditions.
- **Role of Patient Preferences:** Limited.
- **Exclusions:** None.
- **Policy Level:** Strong recommendation against.

STATEMENT 6. RETROCOCHLEAR PATHOLOGY:

Clinicians should evaluate patients with ISSNHL for retrocochlear pathology by obtaining an MRI, auditory brainstem response (ABR), or audiometric follow-up. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile for Statement 6:

- **Aggregate Evidence Quality:** Grade C.
- **Benefit:** Identify brain tumors, identify conditions that might benefit from early treatment, patient peace of mind, supporting idiopathic diagnosis.
- **Risk, Harm, Cost:** Procedure-specific risks/costs, anxiety and stress.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** Although the panel agreed that the MRI is the most sensitive means for diagnosing retrocochlear pathology, there was no consensus that identifying this pathology would in all cases influence outcomes. The panel therefore concluded that ABR and follow-up audiometry would be acceptable alternatives for initial follow-up of SSNHL as long as there is appropriate counseling about the limitations of these modalities.
- **Intentional Vagueness:** None.
- **Role of Patient Preferences:** Limited in deciding whether or not to assess for retrocochlear pathology, but substantial

in making shared decisions with the clinician for using MRI, ABR, or audiology as the diagnostic test.
- **Exclusions:** None.
- **Policy Level:** Recommendation.

STATEMENT 7. PATIENT EDUCATION:

Clinicians should educate patients with ISSNHL about the natural history of the condition, the benefits and risks of medical interventions, and the limitations of existing evidence regarding efficacy. *Strong recommendation based on systematic reviews with a preponderance of benefit over harm.*

Action Statement Profile for Statement 7:

- **Aggregate Evidence Quality:** Grade B.
- **Benefit:** Facilitate shared decision-making, increase patient adherence to proposed therapy, empower patients, informed consent, link evidence to clinical decisions.
- **Risk, Harm, Cost:** Time spent, miscommunication, patients get overwhelmed, patient anxiety.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** Shared decision-making is beneficial.
- **Intentional Vagueness:** None.
- **Role of Patient Preferences:** Large.
- **Exclusions:** None.
- **Policy Level:** Strong recommendation.

STATEMENT 8. INITIAL CORTICOSTEROIDS:

Clinicians may offer corticosteroids as initial therapy to patients with ISSNHL. *Option based on systematic reviews of randomized control trials with a balance between benefit and harm.*

Action Statement Profile for Statement 8:

- **Aggregate Evidence Quality:** Grade B, based on, systematic reviews of randomized trials with methodological limitations.
- **Benefit:** Hearing improvement.
- **Risk, Harm, Cost:** Oral corticosteroids: Suppression of hypothalamic-pituitary-adrenal axis and Cushing's like syndrome, minimal with 10-14 day treatment; low cost. Intratympanic corticosteroids: minimal systemic effect; local reactions of pain, tympanic membrane perforation, transient dizziness; high cost and multiple office visits.
- **Benefit-Harm Assessment:** Balance of benefit versus harm.
- **Value Judgments:** Even a small possibility of hearing improvement makes this a reasonable treatment to offer patients, considering the profound impact that a quality of life hearing improvement may offer.
- **Intentional Vagueness:** None.
- **Role of Patient Preferences:** Large role for shared decision making with patients.
- **Exclusions:** Oral steroids: medical conditions affected by corticosteroids, such as insulin-dependent or poorly controlled diabetes, tuberculosis, peptic ulcer disease, among others.
- **Policy Level:** Option.

STATEMENT 9. HYPERBARIC OXYGEN THERAPY:

Clinicians may offer hyperbaric oxygen therapy within three months of diagnosis of ISSNHL. *Option based on systematic reviews of randomized control trials with a balance between benefit and harm.*

Action Statement Profile for Statement 9:

- **Aggregate Evidence Quality:** Grade B, based on systematic review of RCTs with methodological limitations.
- **Benefit:** Hearing improvement.
- **Risk, Harm, Cost:** Costs, patient time/effort, patient anxiety and stress, barotraumas, otitis media, oxygen toxicity, worsening of cataracts, fatigue, death.
- **Benefit-Harm Assessment:** Equilibrium.
- **Value Judgments:** Although HBOT is not widely available in the U.S. and is not recognized by many U.S. clinicians as an intervention for ISSNHL, the panel felt that the level of evidence for hearing improvement, albeit modest and imprecise, was sufficient to promote greater awareness of HBOT as an intervention for ISSNHL.
- **Intentional Vagueness:** None.
- **Role Of Patient Preferences:** Large role for shared decision-making.
- **Exclusions:** None.
- **Policy Level**: Option.

STATEMENT 10. OTHER PHARMACOLOGIC THERAPY:

Clinicians should not routinely prescribe antivirals, thrombolytics, vasodilators, vasoactive substances, or antioxidants to patients with ISSNHL. *Recommendation against based on systematic reviews of RCTs with a preponderance of harm over benefit.*

Action Statement Profile for Statement 10:

- **Aggregate Evidence Quality:** Grade B.
- **Benefit:** Avoidance of unnecessary treatment, avoid adverse events of unnecessary treatment, cost saving.
- **Risk, Harm, Cost:** None as the recommendation is against the use of these therapies.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** None.
- **Intentional Vagueness:** The word "routine" is used to avoid setting a legal standard recognizing that there may be patient specific indications for one or more of these therapies that may be reasonable to try on an individualized basis, with shared decision making.
- **Role of Patient Preferences:** None.
- **Exclusions:** None.
- **Policy Level:** Recommendation against.

STATEMENT 11. SALVAGE THERAPY:

Clinicians should offer IT steroid perfusion when patients have incomplete recovery from ISSNHL after failure of initial management. *Recommendation based on RCTs with a preponderance of benefit over harm.*

Action Statement Profile for Statement 11:

- **Aggregate Evidence Quality:** Grade B, based on RCTs with limitations.
- **Benefit:** Hearing recovery.
- **Risk, Harm, Cost:** Perforation, discomfort, cost, patient anxiety.
- **Benefit-Harm Assessment:** Preponderance of benefit over harm.
- **Value Judgments:** None.
- **Intentional Vagueness:** Patients qualifying for salvage therapy have failed to respond to initial management or have had an incomplete response. Failure of initial management is not clearly defined as there is limited guidance from the literature as to what level of residual hearing loss qualifies a patient for salvage. The guideline panel recognized that varying degrees of hearing loss will affect patients differently. This may govern the aggressiveness of the decision to pursue further therapy.
- **Role of Patient Preferences:** Significant role for shared decision-making regarding treatment options depending upon various perceived levels of hearing impairment.
- **Exclusions:** None.
- **Policy Level:** Recommendation.

STATEMENT 12. OUTCOMES ASSESSMENT:

Clinicians should obtain follow-up audiometric evaluation within six months of diagnosis for patients with ISSNHL. *Recommendation based on observational studies with a preponderance of benefit over harm.*

Action Statement Profile for Statement 12:

- **Aggregate Evidence Quality:** Grade C, based on observation studies.
- **Benefit:** Assess outcome of intervention, identify patients who may benefit from audiologic rehabilitation, identify cause of hearing loss, identify progressive hearing loss, improve counseling.
- **Risk, Harm, Cost:** Procedural cost.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** The patient perception of hearing recovery is not always completely accurate and patients may be unaware of a residual hearing impairment that could be identified through audiometric assessment. Patients who report subjective hearing improvement may still derive additional benefits from objective testing.
- **Intentional Vagueness:** None.
- **Role of Patient Preferences:** Some.
- **Exclusions:** None.
- **Policy Level:** Recommendation.

STATEMENT 13. REHABILITATION:

Clinicians should counsel patients with incomplete recovery of hearing about the possible benefits of amplification and hearing assistive technology (HAT) and other supportive measures. *Strong recommendation based on systematic reviews and observational studies with a preponderance of benefit over harm.*

Action Statement Profile for Statement 13:

- **Aggregate Evidence Quality:** Grade B, based on systematic reviews and observational studies.
- **Benefit:** Improved quality of life, improved functionality, emotional support, improved hearing.
- **Risk, Harm, Cost:** Time and cost of counseling.
- **Benefit-Harm Assessment:** Preponderance of benefit.
- **Value Judgments:** None.
- **Intentional Vagueness:** None.
- **Role of Patient Preferences:** Patient may decline counseling.
- **Exclusions:** None.
- **Policy Level:** Strong recommendation.

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Reference

1. Byl FM. Seventy-six cases of presumed sudden hearing loss occurring in 1973: prognosis and incidence. *Laryngoscope*. 1977;87:817-25.
2. Mattox DE, Simmons FB. Natural history of sudden sensorineural hearing loss. *Ann Otol Rhinol Laryngol*. 1977;86:463-80.
3. National Institute of Deafness and Communication Disorders. Sudden deafness. http://www.nidcd.nih.gov/health/hearing/sudden.htm 2000; Accessed May, 18, 2011.
4. Saunders JE, Luxford WM, Devgan KK, et al. Sudden hearing loss in acoustic neuroma patients. 1995;113:23-31.
5. Rauch SD. Clinical practice. Idiopathic sudden sensorineural hearing loss. *N Engl J Med*. 2008;359:833-40.
6. Conlin AE, Parnes LS. Treatment of sudden sensorineural hearing loss: II. A Meta-analysis. *Arch Otolaryngol Head Neck Surg*. 2007;133:582-6.
7. Conlin AE, Parnes LS. Treatment of sudden sensorineural hearing loss: I. A systematic review. *Arch Otolaryngol Head Neck Surg*. 2007;133:573-81.
8. Fetterman BL, Saunders JE, Luxford WM. Prognosis and treatment of sudden sensorineural hearing loss. *Am J Otol*. 1996;17:529-36.
9. Haynes DS, O'Malley M, Cohen S, et al. Intratympanic dexamethasone for sudden sensorineural hearing loss after failure of systemic therapy. *Laryngoscope*. 2007;117:3-15.
10. Penido Nde O, Ramos HV, Barros FA, et al. Clinical, etiological and progression factors of hearing in sudden deafness. 2005;71:633-8.
11. Hol MK, Bosman AJ, Snik AF, et al. Bone-anchored hearing aids in unilateral inner ear deafness: an evaluation of audiometric and patient outcome measurements. *Otol Neurotol*. *Braz J Otorhinolaryngol*. 2005;26:999-1006.
12. Nadol J, Wilson W. Treatment of sudden hearing loss is illogical. In: *Controversy in Otolaryngology*. Snow J, editor. Philadelphia: W.B. Saunders Co.; 1980. p. 22-32.
13. Rauch SD, Halpin CF, Antonelli PJ, et al. Oral vs intratympanic corticosteroid therapy for idiopathic sudden sensorineural hearing loss: a randomized trial. *JAMA*. 2011;305:2071-9.

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Make Your Voice Count This World Voice Day

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The theme for World Voice Day 2012 is Make Your Voice Count. This is a simple phrase, and yet if you pause to consider it further you can find meaning on so many different levels.

At perhaps the most fundamental level, it reminds us that our voice is essential for any number of basic activities that might be done on a given day. Yes, this could even include counting out loud, but also speaking with colleagues at work, placing an order in a restaurant, or just saying "good morning" to a friend or spouse.

If you think of it on a different level and with particular emphasis, Make Your *Voice* Count, it brings to mind the fact that voice is part of our individual personality and identity. For most people, it is words from our unique human instrument that serve as our ambassador to the world around us. Even in a contemporary society that is actively engaged with social media, texting and tweeting, first impressions are frequently based upon our voice. It can portray confidence, uncertainty, friendship, anger and many other sentiments. We also make a deep connection with the voices of our loved ones: think of the last time that you told someone, "It is so good just to hear the sound of your voice." Similarly, what young parent is not overjoyed and filled with wonder at hearing their child's first words?

Thought of in yet another way, Make *Your* Voice Count, it is a reminder that every individual has the right to a voice in the concerns of our collective world. This past year has seen many examples of individuals rising up to be certain that their voice was heard. Popular uprisings in the Middle East or the Occupy Movement in the United States are well known examples of voices speaking out. The United States will also hold a presidential election in 2012, employing a democratic process that is intended to leave no voice unheard. It matters that every person has a voice.

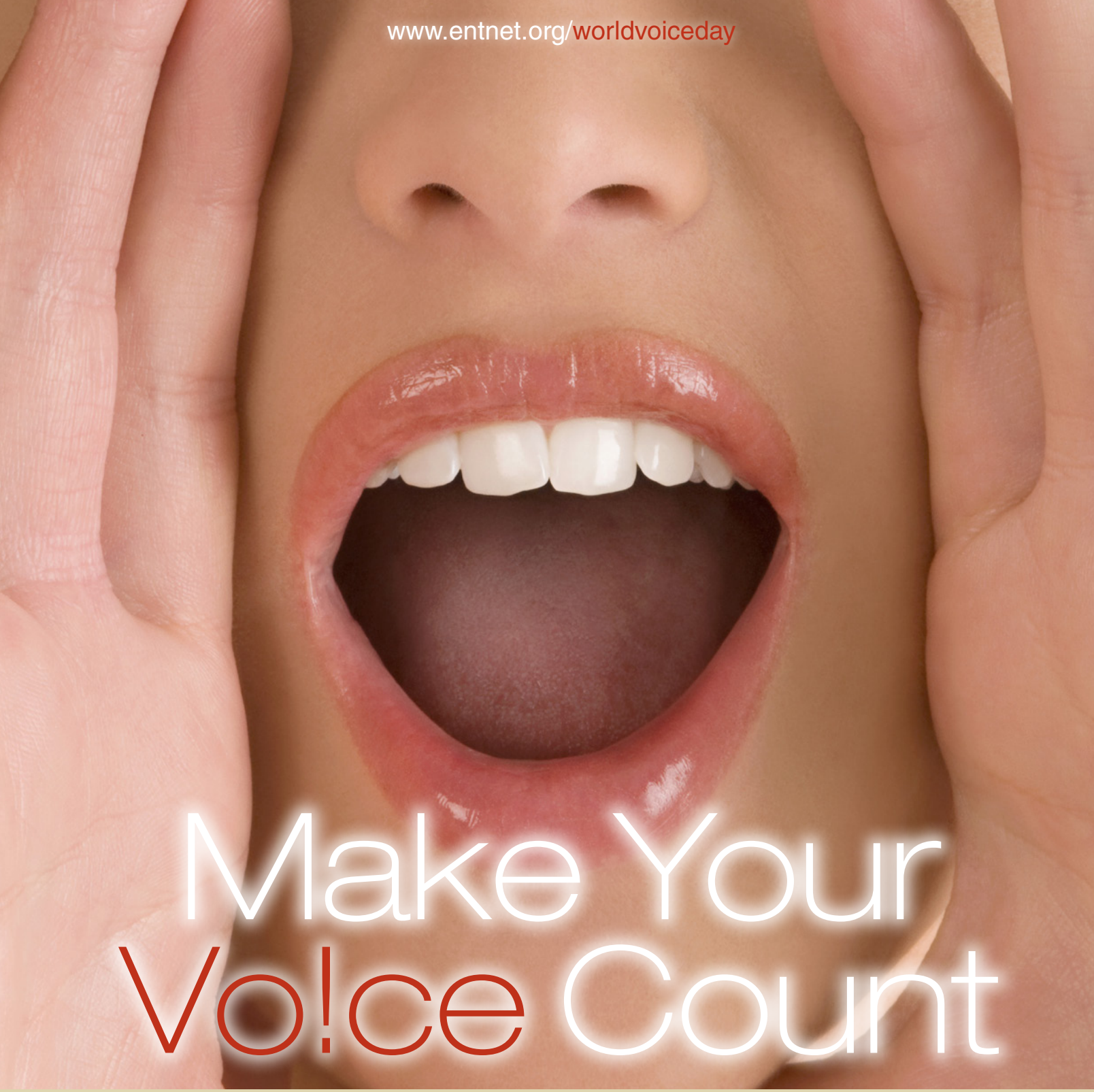
Norman D. Hogikyan, MD

World Voice Day is a time to celebrate the voice and also a time to promote awareness about vocal health. Many people will not have thought about the importance of vocal health unless they or someone close to them has experienced a significant voice disorder. A great thing about the larynx or voice box is that we are born with it as our natural instrument; there is not even an "app" you need to download to use it. Unlike an instrument like a trumpet or guitar though, we cannot carefully put it away into a protective case whenever we are not using it. The human voice box or larynx is constantly exposed to potential injury or irritation, but fortunately we can prevent many types of voice problems by following a few simple vocal health guidelines.

To help ensure that you can count on your voice now and in the future:

- Never smoke.
- Keep yourself well hydrated. Water is the best.
- Don't scream or shout. Use a microphone if you need to project your voice.
- Rest your voice if you have laryngitis.
- Get evaluated by an otolaryngologist (ear, nose and throat physician) if you have persistent hoarseness.

www.entnet.org/worldvoiceday



Make Your Vo!ce Count

AAO-HNS supports

WORLD VOICE DAY

April 16th

OCST Is the Hot Button Issue for the Sleep Disorders Committee

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

As the nation grows older and more obese, out-of-center sleep testing (OCST) is keeping the Sleep Disorders Committee of the American Academy of Otolaryngology—Head and Neck Surgery up at night.

Portable monitoring, home sleep testing, and ambulatory sleep testing for obstructive sleep apnea (OSA) are influencing the payment structure, with insurer spending on the procedure under government scrutiny. According to the Office of the Inspector General in the Department of Health and Human Services, Medicare spending on sleep testing increased nearly 280 percent from 2001 to 2009—from $62 million to $235 million.

The problem for physicians, said **Edward M. Weaver, MD, MPH**, associate professor and chief of sleep surgery in the department of otolaryngology—head and neck surgery at the University of Washington in Seattle, is that insurers are pushing for in-home testing using a portable device in lieu of the more expensive, overnight sleep lab option.

"Some health plans now require OCST for suspected sleep apnea, and probably more plans will require it in the future," Dr. Weaver said. "This change alters the landscape of reimbursement for sleep medicine, because polysomnography costs and reimburses much more than OCST. In-lab testing has been the major source of revenue for most sleep medicine programs."

Academy Sleep Disorders Committee Chair **Pell Ann Wardrop, MD**, medical director of the St. Joseph Hospital's Sleep Wellness Center in Lexington, KY, said that she sees one insurer's new policy for sleep testing as a good example of the problem.

"In a couple of geographic areas, the insurer has initiated a new program that requires patients be tested with a home sleep test unless these patients have specific co-morbid conditions," Dr. Wardrop said. "That is fine in some cases, but many times the patients receive the instructions by mail, and even if that is not the case, the physician cannot individualize the test for the particular patient. Right now the Academy is working to advocate for payment for surgical sleep procedures and access to a variety of treatment options for sleep patients in both Massachusetts and New York, as well as a couple other areas of the country."

Dovetailing with the sleep center controversy is the growing interest in outcomes-based care, Dr. Weaver said.

"Models of care are being considered where reimbursement and coverage of services are determined by outcome, not just service provided," he said. "For example, Medicare will cover a continuous positive airway pressure (CPAP) device only if the patient demonstrates adequate use during the initial trial period. Medicare defines adequate use—objectively measured by the CPAP device—as an average of four hours per night on 70 percent of nights during a consecutive 30-day period within the first 90 days of the CPAP trial."

Both issues may have downstream effects on the practice of sleep surgery, as more OCST may provide easier access for patients to be diagnosed with OSA and increase the need for sleep surgery, Dr. Weaver said.

"Some speculate these patients will not receive as thorough a trial of CPAP, which may translate to a higher rate of

failed CPAP patients, which in turn would further increase the downstream need for sleep surgery," he said. "Likewise, greater scrutiny for CPAP coverage will likely identify CPAP failures more readily and may result in more patients being referred for surgical treatment alternatives to CPAP. One of the challenges for otolaryngology is to have a sufficient number of surgeons trained adequately in the surgical treatment of sleep apnea."

Education

According to Dr. Wardrop, the Sleep Disorders Committee has spent the last year and a half updating the bulk of the patient education material related to sleep disorders on the AAO-HNS website.

"We have also updated many of the sleep-related clinical indicators and policy statements as part of (AAO-HNS President) **Rodney P. Lusk, MD's**, Web Content Relevancy Project—an Academy-wide push to index everything and make our search functions work better."

Dr. Wardrop said the members of the committee have also developed several soon-to-be-released AcademyU® sleep-related modules, and are also working collaboratively with other committees and societies on quality issues and payment/access to care issues.

"We are also involved in the research arena," she said. "The committee identified several areas in which there was a paucity of clinical data. Based upon these discussions, **Kathleen Yaremchuk, MD,** and **Andrew J. Senchak, MD**, are both leading studies investigating the effect of tonsillectomy in adult OSA."

It is important to recognize that sleep-disordered breathing and OSA are increasingly diagnosed in children, said Ron Mitchell, MD, professor of Otolaryngology and Pediatrics at UT Southwestern Medical Center, Dallas and chief of pediatric otolaryngology at Children's Medical Center Dallas. This reflects the recognition that OSA affects up to 2 percent of normal-weight, and 20 percent of overweight and obese children. Adenotonsillectomy (T&A) is the first line surgical treatment for OSA in children with more than 500,000 procedures performed annually in the United States. There is an ongoing debate about indications for polysomnography (sleep studies) prior to T&A for OSA in children.

The AAO-HNSF published a guideline in 2011 on polysomnography for sleep-disordered breathing prior to tonsillectomy in children (http://oto.sagepub.com/content/145/1_suppl/S1). It consists of five evidence-based action statements that deal with indications for polysomnography, the need to advocate for polysomnography in certain groups of children, the need to communicate the results of polysomnography with the anesthesiologist, indication for admission to hospital after T&A, and the need to obtain full-night polysomnography instead of portable monitoring to diagnose and quantify OSA. The purpose of the guidelines is to define actions that could be taken by otolaryngologists to deliver quality care, Dr. Mitchell said.

Annual Meeting Research Track

This year's Translational Research Mini-Program at the AAO-HNSF 2012 Annual Meeting & OTO EXPO in Washington, D.C., will continue the focus on sleep. Dr. Weaver, the Mini-Program chair, said the committee that put the event together sought to cover a broad spectrum of topics relevant to sleep apnea and surgical treatment, with a focus on research topics and data. The topics range from basic science relevant to understanding the upper airway pathology (miniseminar No. 1), to data on emerging surgical treatments (miniseminar No. 2), to research that influences policies relevant to sleep surgery (miniseminar No. 3).

"This Mini-Program will highlight major advances in the field of sleep apnea research relevant to surgery, and it will point to important areas in need of deeper understanding at each level from bench to policy development," Dr. Weaver said. "We targeted speakers known to give engaging presentations."

Dr. Weaver said the committee chose speakers who have received "excellent audience feedback" in regard to their respective topics.

"The guest speakers are leaders in the field of sleep medicine," he said. "Allan Pack, MD, PhD, director of the division of sleep medicine at the University of Pennsylvania, will give the Neel Lecture

on the genetics of obstructive sleep apnea. He is a world-renowned expert in the field and a dynamic speaker."

The 2012 Neel Distinguished Research Lecture will overview genetics in the context of OSA, sharing both experience and data from a large genetics study Dr. Pack is leading in Iceland, an area that provides unique advantages for genetics studies.

"The Icelandic population was in isolation for centuries, so it has a relatively homogeneous gene pool, which helps for gene studies," Dr. Weaver said. "Moreover, the population is highly supportive of gene studies, so more than half the population has provided material for complete genotyping. With a close collaboration with the sleep medicine program in Iceland—where a large number of patients have been thoroughly phenotyped for OSA, including polysomnography, airway MRI, and other anatomical and physiological measures—the data provide a unique opportunity to study genetic influences on OSA."

Atul Malhotra, MD, director of the Sleep Program at Harvard's Brigham & Women's Hospital and an international leader on normal upper airway physiology and sleep apnea airway pathophysiology, will be featured in the basic science miniseminar.

"While otolaryngologists are expert in assessing the anatomical features of the upper airway, the physiological basis of upper airway collapse during sleep is not as well understood by most otolaryngologists," Dr. Weaver said. "This miniseminar will highlight a world expert on physiological upper airway dynamics and how it relates to OSA. An intriguing pathophysiologic theory about OSA is that vibration trauma of snoring creates upper airway neuropathy that worsens upper airway stability."

Nelson B. Powell, MD, DDS, a clinical professor of Sleep Medicine at Stanford University, is a pioneer of sleep surgery and sleep research who will speak on a new area of research using computational fluid dynamics to understand airflow and its interactions with the airway in normal and sleep apnea patients.

"[Dr. Powell] ultimately may inform us on important anatomical targets and approaches for surgical treatment," Dr. Weaver said. "Innovations in surgical treatment of OSA include modification and refinements of existing techniques, topics covered in instruction courses annually at the AAO-HNSF meeting. Promising new innovations also include using new technologies, new approaches, and newly invented devices to address upper airway collapse during sleep."

Dr. Weaver said robotic approaches for pharyngeal surgery are being tested for OSA, and early data on this approach will be presented, along with three hypoglossal nerve stimulation devices, which are in various stages of human testing and show early promise as a tool to treat tongue-base obstruction in OSA.

"A review of the latest available data for this approach will be presented," he said. "Other new devices and approaches will also be covered, some with more data than others. Thus, this miniseminar serves to review data on the latest cutting

edge technologies used to treat OSA surgically, and it complements the two other miniseminars proposed as part of the Basic & Translational Research Mini-Program on OSA."

The third, and last, miniseminar will discuss recently published reviews of sleep surgery that focus on sleep testing outcomes, review data on sleep surgery outcomes and present new data on cost-effectiveness of sleep surgery.

"Several reviews and guidelines for the treatment of OSA have been published in the last few years," Dr. Weaver said. "The reviews and criticisms of surgical treatment outcomes have focused largely on inadequate cure rates of OSA as measured by the apnea-hypopnea index. This miniseminar reviews the state of the sleep surgery literature and policy, and it looks forward to data and models that may help dictate future policy for the role of sleep surgery."

Looking Ahead

According to Dr. Weaver, integration of services is the next breakthrough for sleep medicine, incorporating multiple specialties—primary care, sleep specialists, and related subspecialists—to manage sleep disorders more comprehensively.

"It will incorporate multiple approaches, such as with OCST and in-lab polysomnography, to optimize treatment outcomes and maximize cost-effectiveness," he said. "It will incentivize treatment outcomes rather than simply treatment volume, and it will include a chronic disease management model, where follow-up is key and clinical outcomes guide protocols and policy."

And while no silver bullets are available to cure sleep apnea, Dr. Weaver said there are a number of new technologies that might offer additional approaches to sleep apnea patients.

"Hypoglossal nerve stimulators are being tested and appear to hold promise, and robotic surgery is gaining attention and may offer advantages for tongue reduction surgery, especially as the robotic tools improve," he said. "One of the major challenges for surgical treatment of sleep apnea is to be able to understand the sites of obstruction and the effects on airflow—normal and abnormal—on the tissues. One promising research technology—computer modeling of the airway and airflow to understand sites of obstruction and effects of impaired airflow—is just emerging for sleep apnea, but may hold promise for future clinical application."

This year will see the completion of a five year study looking at the efficacy of T&A for OSA in children. The Childhood Adenotonsillectomy (CHAT) study is an NIH/ NHLBI-sponsored study of 500 children with mild-to-moderate OSA in six clinical sites who were randomized to T&A or watchful waiting. "This is the largest study to date looking at the surgical efficacy of T&A in children with OSA," said Ron Mitchell, MD, one of the site PIs for the study. "We are excited to be able to analyze the data and plan more clinical studies in the future."

Make an 'Investment' in Your Future

Are you a 2012 ENT PAC Investor? The AAO-HNS political action committee is only as strong as you—its members! As we continue to face the uncertainties surrounding healthcare reform implementation, Capitol Hill is in election mode. We must mobilize now to ensure new and returning Members of Congress understand and support our legislative priorities. If every PAC-eligible member of the AAO-HNS made a contribution of at least $100 in 2012, we would have almost $1 million in our ENT PAC coffers.

To make your 2012 ENT PAC investment online, visit www.entnet.org/entpac (AAO-HNS member log-in required) or send your personal check (payable to ENT PAC) to 1650 Diagonal Road, Alexandria, VA, 22314. Invest in your future today!

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

Stay Informed by Visiting the Government Affairs Website

To receive the most up-to-date news on all federal, state, and political issues affecting otolaryngology–head and neck surgery, AAO-HNS members are encouraged to bookmark the Academy's Legislative and Political Affairs web page. Members have access to reports on the recent activity in Congress and in statehouses across the country, news regarding the 2012 Congressional elections, and more. Bookmark this important page today by visiting www.entnet.org/Advocacy.

Advocate at a Higher Level: Register for the 2012 OTO Advocacy Summit

Register now to attend the 2012 OTO Advocacy Summit. To accommodate our members' demanding schedules, this year's summit is scheduled for May 7-8 in conjunction with the spring Board of Governors Spring Meeting May 6-7. Attendees will participate in legislative advocacy training sessions, hear "insider" reports from Capitol Hill, and be offered pre-scheduled meetings with Members of Congress and/or their staffs. There will also be ample networking opportunities and an exclusive ENT PAC reception at the historic George Washington Masonic Memorial.

Act now to heighten your advocacy skills on Capitol Hill by registering at www.entnet.org/BOG&Summit or completing the registration form in this issue of the *Bulletin*.

BOG & OTO

Board of Governors SPRING MEETING

Otolaryngology ADVOCACY SUMMIT

2012 Board of Governors Spring Meeting and OTO Advocacy Summit

May 6 – 8, 2012

Hilton Old Town Alexandria Hotel
1767 King Street, Alexandria, VA 22314
Online Registration at www.entnet.org/bog&summit

Contact Information:

First Name (Please Print) _____ MI _____ Last Name _____ Member ID# _____

Home Address _____ City/State/Zip _____

(_____)_____ Daytime Phone (_____)_____ Mobile Phone (optional) (_____)_____ Fax _____ Email

Do you have any special physical, dietary (for example, vegetarian, kosher), or other needs? ☐YES ☐NO

If yes, please describe_____

Agenda (*tentative*):

BOARD OF GOVERNORS SPRING MEETING

Sunday, May 6

Registration Open	**10:30 AM – 5:00 PM**
☐ Luncheon/Ice-Breaker Event	**11:30 PM – 12:30 PM**
☐ BOG Socioeconomic & Grassroots Committee Meeting	**12:40 PM – 1:55 PM**
☐ BOG Legislative Representatives Committee Meeting	**2:05 PM – 3:15 PM**
Concurrent Breakout Sessions (select from one of the following groups to attend)	**3:30 PM – 5:00 PM**
☐ Group 1	
Entrepreneur Workgroup	**3:30 PM – 4:15 PM**
Nuts & Bolts of Meaningful Use	**4:15 PM – 5:00 PM**
☐ Group 2	
Nuts & Bolts of Meaningful Use	**3:30 PM – 4:15 PM**
Entrepreneur Workgroup	**4:15 PM – 5:00 PM**
☐ Group 3	
Public Relations/Media Workgroup	**3:30 PM – 5:00 PM**
BOG Executive Committee (*By Invitation Only*)	**5:10 PM – 5:45 PM**

Monday, May 7

Registration Open	**7:00 AM – 8:00 AM**
☐ Society Information Sharing Breakfast	**7:30 AM – 8:30 AM**
☐ Keynote Address	**8:30 AM – 9:30 AM**
"The Brave New World: Hospitals, Healthcare Systems, & the Modern Otolaryngologist"	
☐ "Developing & Patenting Your Ideas"	**9:45 AM – 10:45 AM**
☐ BOG General Assembly	**11:00 AM – 12:00 PM**

OTO ADVOCACY SUMMIT

Sunday, May 6

☐ ENT PAC Reception (Ticket Required)	**5:30 PM – 7:30 PM**

Monday, May 7

☐ OTO Advocacy Summit Luncheon	**12:00 PM – 1:00 PM**
☐ Advocacy Briefing	**1:15 PM – 2:30 PM**
☐ Congressional Speakers	**2:30 PM – 4:00 PM**
☐ Advocacy Do's & Don'ts	**4:00 PM – 5:00 PM**
☐ Monument Tour*	**5:45 PM – 8:00 PM**

***shuttle drop location will provide easy access to MLK, Lincoln, Jefferson, WWII, and Washington Monuments/Memorials (limited availability)**

Tuesday, May 8

☐ Breakfast Briefing	**7:00 AM – 8:30 AM**
☐ Pre-Scheduled Congressional Visits	**9:30 AM – 2:30 PM**
☐ De-Briefing/Lunch*	

*AAO-HNS Capitol Hill Office, Washington, DC

IMPORTANT NOTES:

- **Attendance is a FREE AAO-HNS Member Benefit!**
- **AAO-HNS staff will schedule your Capitol Hill visits.**
- **Transportation provided to Capitol Hill.**
- **Please plan flight departures NO EARLIER than 4:00 PM on Tuesday, May 8, 2012.**

Hotel Accommodations:
Hotel Reservations can be made separately at the Hilton Old Town Alexandria Hotel in the group block named **BOG Spring Meeting and OTO Advocacy Summit**. The group has rooms available from May 4 - May 9, 2012. Reservations made in this block will receive a special rate of $175 ++single/double per night. Housing deadline is March 25, 2012. To make reservations, please visit www.entnet.org/bog&summit.

Send Completed Registration Form to: AAO-HNS Member Services,1650 Diagonal Rd, Alexandria, VA 22314 or Fax to 202-544-8454

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Empowering otolaryngologist—head and neck surgeons to deliver the best patient care
1650 Diagonal Road, Alexandria, Virginia 22314-2857 U.S.A.

CMS Innovation Advisors Program

In January, the Centers for Medicare and Medicaid Services (CMS) selected 73 participants for their Innovation Advisors Program. Advisors participating in the program include clinicians, allied health professionals, health administrators, and others. While serving in the Advisors Program, these individuals will act as advisors for the CMS Innovation Center and work to test new models of care, such as Accountable Care Organizations (ACO) and Bundled Payments for Care Improvements in their own programs.

> CMS plans to expand the Advisors Program to include as many as 200 people from across the country in the first year of the program.

CMS plans to expand the Advisors Program to include as many as 200 people from across the country in the first year of the program. According to CMS, program activities are expected to take up to 10 hours each week during the first six-month orientation and applied research period, and with similar involvement, depending on the individual's work plan, for the duration of their time as an advisor. Advisors will meet in remote virtual sessions as needed, have regional meetings quarterly, and meet at CMS once each year to discuss progress. Once accepted, participant organizations or groups will make arrangements with advisors. Participants are eligible for a stipend of up to $20,000.

It is anticipated that people wishing to participate in the Advisor Program will be able to apply this spring and applicants will be selected by June. Look to "The News" and other announcements from the Academy if you are interested in applying to serve as an advisor. This is a critical time to become involved as regulators explore new business models and payment systems to direct our healthcare system in the future.

For more information on the CMS Innovation Advisors Program, visit the website at http://tinyurl.com/6vyzjvq If you have any questions regarding the Innovation Center or the Advisors Program, contact the Health Policy team at healthpolicy@entnet.org.

Tracheotomy Articles Are a Triumph of Collaboration

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

The AAO-HNS Patient Safety and Quality Improvement Committee and the Airway and Swallowing Committee have collaborated to publish a series of manuscripts on tracheotomy outcomes from myriad sources, utilizing a number of differing research methodologies.

> In the world of patient safety and quality improvement, it is important that deference to the expert is maintained. Hence, it is somewhat disingenuous for any such committee to meddle, so to speak, into the nuances of care delivery and outcomes of disease states that are not in its direct purview.

With the guidance of Academy member **Albert L. Merati, MD**, the committees united their resources to publish what we know as the largest series of articles on tracheotomy outcomes in the literature. The significance is two-fold: 1. The articles represent a significant contribution to the regarding outcomes of patients with tracheotomies with doable items that have the potential to materially decrease adverse events and outcomes from tracheotomies. 2. The collaboration between the committees should be viewed as a model, not only within healthcare between distinct types of providers, but also within the Academy as an exercise that highlights partnership between otolaryngology specialties (many members from each respective committee are active in other special-focus specialty societies) and stakeholders.

We have all known or experienced a disastrous tracheotomy outcome. However, in patient safety and quality improvement, when there are one-off events, the need to quantify the frequency of the event is important. Institutional studies are simply not powered to do this. Furthermore, it may be that the events are so rare that the frequency of such an event cannot be estimated. Nevertheless, in the tracheotomy papers three various methodologies were employed in an effort to obtain a realistic perspective on the incidence and potential opportunity for intervention in patients with tracheotomies.

It was interesting that using disparate methodologies, such as conducting a national survey of surgeons, providing an analysis of a national admissions database, and researching a multi-institutional "mega-database" spearheaded by the AAO-HNS Airway and Swallowing Committee, the conclusions, imperatives, and opportunities are quite consistent. There are several action items and potential avenues for improvement from the findings of these four articles and these are articulated in an accompanying editorial by Academy members **David E. Eibling, MD**, and **David W. Roberson, MD.** The articles were published in the January issue of *The Laryngoscope*.

The articles took a herculean effort in coordination and execution so that all the papers, which were quite large in scope, could be published in the same issue. It helps readers, especially non-otolaryngologists, to understand the scope of the problem being studied and helps to juxtapose various methodologies to allow the reader to realize the value of the results and the conclusions.

The goal would be for the individual or patient safety and quality organization to read this suite of papers and become energized, as we are, with the potential for a care bundle or intervention to specifically target the issues raised by the articles. Such an initiative would, of course, need to be coordinated at a national level as tracheotomy care and outcomes transcend any one specialty or stake holder. However, the proof-of-principle, that two AAO-HNS/F committees can combine resources and their collective enthusiasm to move the discussion towards such a lofty goal, is demonstrated.

In the world of patient safety and quality improvement, it is important that deference to the expert is maintained. Hence, it is somewhat disingenuous for any such committee to meddle, so to speak, into the nuances of care delivery and outcomes of disease states that are not in its direct purview. A robust methodology for patient safety and quality improvement is to have the content experts partner with those trained in quality measurement, research, etc., in order to best understand the scope of a problem and develop targeted efforts to mitigate risk. Hopefully, the collaboration, which resulted in the manuscripts noted above, will be a template for others to follow when studying patient safety and outcomes as most zones of risk are multidisciplinary and need a team of content experts to properly address the system defects.

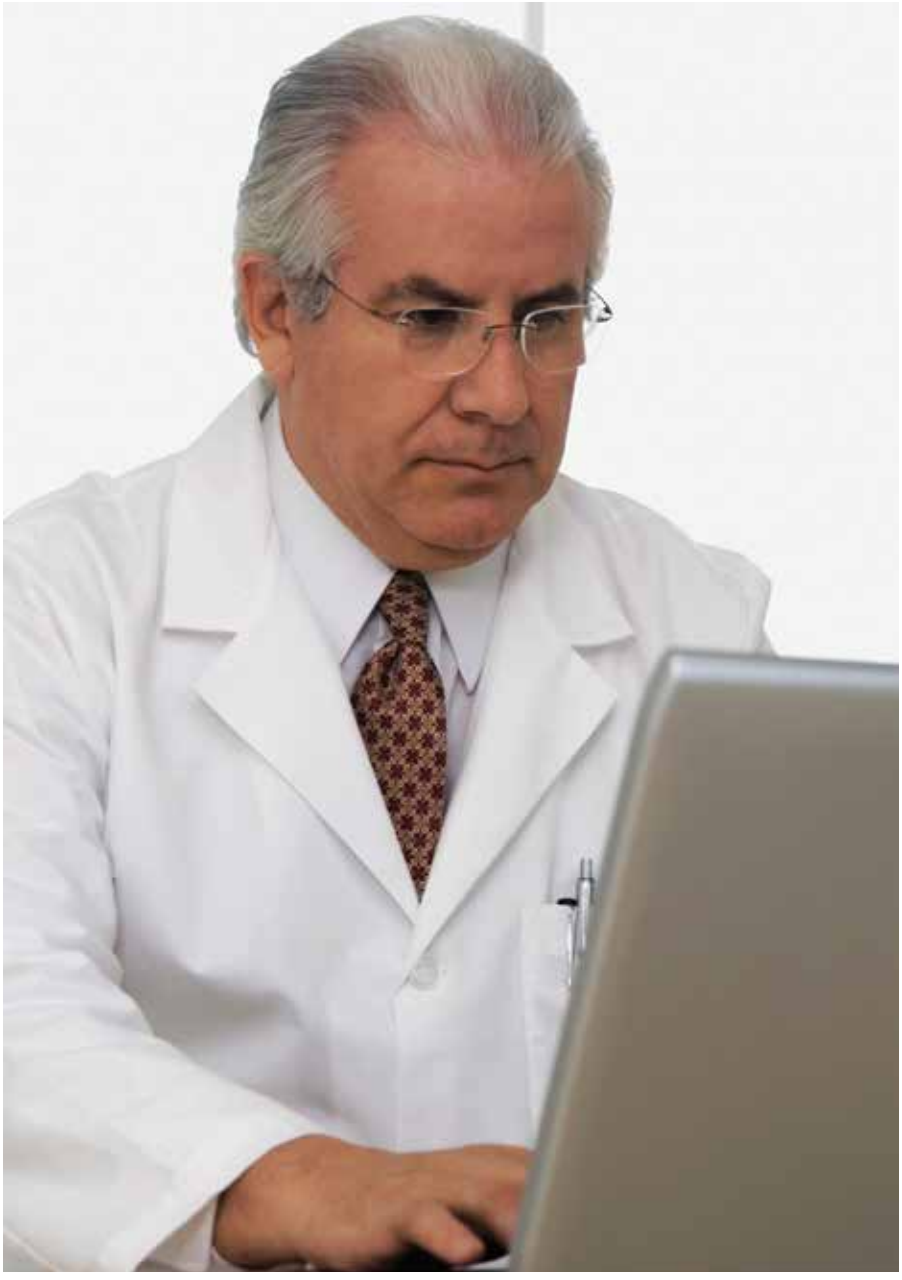
We encourage members to write us with any topic of interest, and we will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Please email the Academy at qualityimprovement@entnet.org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

Clarifying Medicare Audiology Billing Services

Recently, the Academy has received numerous questions from members on Medicare audiology billing and what services audiology/otolaryngology-technicians (oto-techs) can bill. In response, resources on the Academy's website have been developed to help to clarify this issue. (See http://www.entnet.org/Practice/Medicareupdates.cfm#AUDHP). Frequently asked questions and answers are provided below, followed by a summary of information provided on our website.

What Services Can Otolaryngology Technicians Provide and Bill?

A physician orders a comprehensive audiometry threshold evaluation and speech recognition test (CPT 92557), but wonders if his/her certified audiology technician or oto-tech can perform and bill for this? The answer is no. According to Medicare, audiology/oto-techs cannot bill Medicare for 92557 because there is no separate professional component (-26)/technical component (TC) breakout where the technician would be able to bill for the TC. However, qualified professionals who have their own Medicare NPI, such as an audiologist, may bill for this.



- In June 2010, CMS released MedLearn Matters 6447, http://www.cms.gov/MLNMattersArticles/downloads/MM6447.pdf, which clarified the Medicare policy on billing for audiology services. CMS indicated that qualified technicians, including those trained in the Academy's Certificate Program for Otolaryngology Personnel (CPOP), can only perform diagnostic audiology tests (under direct physician supervision) that have a technical and professional component. In such cases, the technicians can only perform the technical component of the test. This revised policy took effect September 30, 2010.

Below are CPT codes for services that oto-techs may perform the technical component of under direct physician supervision (note that for these CPT codes the physician, non-physician practitioner, or audiologist must perform the professional component of the tests):

- 92540 - Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording; positional nystagmus test, minimum of four positions, with recording; optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording; and oscillating tracking test, with recording
- 92541 - Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording

- 92542 - Positional nystagmus test, minimum of four positions, with recording
- 92543 - Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
- 92544 - Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
- 92545 - Oscillating tracking test, with recording
- 92546 - Sinusoidal vertical axis rotational testing
- 92548 - Computerized dynamic posturography
- 92585 - Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
- 92587 - Evoked otoacoustic emissions; limited (single stimulus level, either transient, or distortion products)
- 92588 - Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
- 92567 - Tympanometry (impedance testing)

It is important to note that for codes where the technician may perform the technical component, he/she must meet qualifications determined by the local Medicare contractor. Medicare allows the Medicare Administrative Contractor (MAC) to determine what services technicians can perform and what the qualifications are. These include, at a minimum, qualification requirements of state and/or local law and successful conclusion of a curriculum, including both classroom training and supervised clinical experience administering the audiological service.

We strongly recommend that the ENT physician leader contact your MAC Medical Director to determine which codes they allow technicians to perform the technical component for. The Academy believes it is helpful for members to establish good relationships with their contractor medical directors for these issues.

"It is important to note that for codes where the technician may perform the technical component, he/she must meet qualifications determined by the local Medicare contractor. Medicare allows the Medicare Administrative Contractor (MAC) to determine what services technicians can perform and what the qualifications are."

What happens to the oto-techs who are well trained through our Academy's CPOP?

Oto-techs can still perform the technical component of diagnostic audiology tests that have a professional and technical component. The physician must detail the specific tests the technician must perform and provide direct supervision. The services can be billed under the name and NPI number of the physician. Contact your MAC to determine the specific diagnostic tests that technicians can perform and for which you will be reimbursed.

The Academy realizes this is a complex issue and other questions may arise, including those involving services performed by an audiologist. The Academy has several resources available to help members navigate Medicare's audiology billing requirements, including a newly revised audiology FAQ available on our website at http://www.entnet.org/Practice/Medicareupdates.cfm#AUDHP. The Academy also provides a coding hotline to members for specific questions about coding. It can be reached Monday through Friday, 7:00 am-4:00 pm MST at 1-800-584-7773. Additional questions can be submitted to the Health Policy team at healthpolicy@entnet.org.

Joint Statement on Consumer-Administered Hearing Tests and Direct-to-Consumer Hearing Aid Sales

Editors Note: As we go to press, this joint statement was developed and accepted by the named collaborators. This is an important position to note with the advent of online hearing evaluations being offered to consumers.

The Academy of Doctors of Audiology (ADA), American Academy of Audiology (AAA), American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), the American Speech-Language-Hearing Association (ASHA), and International Hearing Society (IHS) stand together, committed to increasing awareness of the benefits of amplification, and to finding safe and effective solutions that help the 75 percent of consumers who could benefit from hearing aids, but cannot afford to purchase them or have chosen not to use them.

While we appreciate the desire of persons, companies, and organizations to reach more individuals in need of hearing aids, our organizations believe that patients must have access to a comprehensive hearing evaluation performed by a hearing health professional, be appropriately fitted by an individual licensed/registered in the state to dispense hearing aids, and have access to auditory rehabilitation and counseling to ensure appropriate fit and use of the hearing aid device. We urge all persons, companies, and organizations who are interested in assisting patients to work with the hearing health community in ensuring that patients have access to the professional services of all qualified hearing health professionals.

Federal and state laws related to the dispensing of a hearing aid are currently in place to protect and ensure consumer safety. Regulations issued by the Food and Drug Administration require that patients younger than age 18 receive a medical evaluation by a licensed physician prior to the purchasing of a hearing aid from a dispenser. A medical evaluation by a licensed physician is also recommended for adults prior to a hearing aid purchase. Many state laws also recognize the importance of consumer protection and safety by placing restrictions on the dispensing of hearing aids by direct mail and/or the Internet.

All of our organizations have both health and efficacy concerns about the use of consumer-administered hearing tests and the direct sale of hearing aids to the consumer without the involvement of a licensed hearing health professional—an audiologist, hearing aid specialist, or otolaryngologist. We encourage our respective members and other hearing health care providers to work collaboratively to ensure patient safety and enhance consumer protections related to the purchase of hearing aids and related devices.

United Healthcare Update

Since releasing its announcement in early October 2011 of its plan to commence a "direct-to-consumer" hearing aid program that includes an online hearing test, AAO-HNS has communicated with United Healthcare (UHC) and hi HealthInnovations (HHI), subsidiaries of United HealthGroup (UHG), about specific Academy concerns, primarily focusing on the lack of quality of care reflected by the program. (See below for a timeline of AAO-HNS advocacy efforts). Subsequently, on November 2, 2011, the Academy submitted comments outlining concerns about the program to the National Medical Director at UHC and received an immediate response resulting in an initial conference call on November 28, 2011 with UHC. After a brief conference call, both parties decided to arrange a face-to-face meeting for a more thorough discussion. UHC initiated its program on January 1, 2012, and included the following states in the program's roll-out: California, Colorado, Florida, Illinois, Kentucky, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, South Carolina, Texas, Tennessee, Virginia, and Wisconsin.

On January 30, 2012, Academy representatives, including leadership, physician and audiology volunteers, and staff, met with UHC leadership at the Academy in Alexandria, VA, to discuss the new HHI program. During the meeting, UHC representatives responded to all of the Academy's concerns expressed in our November 2, 2011, comment letter and provided a detailed explanation of their methodology. After gaining a more comprehensive level of insight regarding the program, the Academy maintains that there continue to be major flaws in HHI's "direct-to-consumer" approach to dispensing hearing aids. The Academy remains concerned regarding the inadequacy of the online testing protocol, red flag symptoms that could go unnoticed, referrals to appropriate hearing healthcare professionals, and potential areas of noncompliance with state and federal regulations. Further, the Academy does not support a "some better than none" approach to hearing healthcare. As the Academy has maintained, the best practice for treating hearing loss involves the otolaryngologist, audiologist, and patient care team members.

> "After gaining a more comprehensive level of insight regarding the program, the Academy maintains that there continue to be major flaws in HHI's "direct-to-consumer" approach to dispensing hearing aids."

AAO-HNS Health Policy senior staff members are in continued communication with American Academy of Audiology (AAA), American Speech-Language-Hearing Association (ASHA), Academy of Doctors of Audiology (ADA), and the International Hearing Society (IHS) to share new information received from UHC. In addition, the Academy continues to maintain collegial communications with UHC to provide input on aspects of its program as it develops, keeping patient safety and quality of care at the forefront. Further, the Academy will continue to seek additional information regarding whether their program is in compliance with state law and FDA regulations.

If you are located in one of the roll-out states and receive feedback from patients who have taken the online hearing test, or ordered the hearing aid from this program that affected the patient's quality of care, please contact the Academy's Health Policy Team at healthpolicy@entnet.org.

Advocacy Effort Timeline

October 3, 2011 – Academy is alerted of hi HealthInnovations' new hearing aid program.

October 24, 2011 – Academy comments about the program in American Medical News.
(found at http://www.ama-assn.org/amednews/2011/10/24/bisb1024.htm)

November 2, 2011 – Comment letter sent to UHC followed by an immediate response from UHC to arrange a conference call.
(found at http://www.entnet.org/Practice/upload/UHG_Ltr_HearingAids_11-02-11.pdf)

November 28, 2011 – Several members from the Academy's physician payment policy group (3P), Board of Governors Chair, and staff conduct a brief conference call with UHC. All parties agree to meet face-to-face.

December 5, 2011 – The Academy follows up with UHC, sending a summary of the conference call and suggesting potential dates for a meeting.

January 30, 2012 – Academy leadership, physician and audiologist volunteers, and staff meet with UHC.

Update from the American College of Surgeons

The American College of Surgeons Advisory Council for Otolaryngology—Head and Neck Surgery has been hard at work representing the interests of our specialty within the "house of surgery." In part, a reflection of the tremendous leadership provided by such individuals as **Gerald B. Healy, MD**, and **Mark C. Weissler, MD**, otolaryngology has been recognized for the first time with a number of honors and distinctions.

> The College continues to expand its educational, clinical, and advocacy activities. In particular, its "Find a Surgeon" feature is enjoying exponential growth in the number of "hits" received.

Many will know that Dr. Healy was the first otolaryngologist to serve as the chair of the College's Board of Regents. The following year, he became the first otolaryngologist to be elected ACS President. His vacant position on the Board of Regents has been filled superbly by Dr. Weissler, who has been extraordinarily active in a number of College committees while also representing the interests of our specialty.

In yet another unprecedented development, **Jonas T. Johnson, MD**, was recently named as the first otolaryngologist to receive the Sheen Award, which is bestowed upon physicians who have made outstanding contributions to mankind through the fields of medicine and medical research.

The College continues to expand its educational, clinical, and advocacy activities. In particular, its "Find a Surgeon" feature is enjoying exponential growth in the number of "hits" received. This is an important benefit for the ACS members, and all otolaryngologists who are Fellows of the College are encouraged to update their profiles to accurately reflect their practices. Member profiles may be updated on the College's web portal at www.efacs.org.

A final, important benefit of our alliance with the College is the multiple funding opportunities available. In particular, there is a generous Clinical Scientist Development Award co-sponsored with the Triological Society, which is designated to provide enhanced funding for researchers who have received a K Award. The submission deadline for this award is June 1. The ACS and AAO-HNS also co-sponsor a Health Policy Scholarship for the program at Brandeis University (**Brian B. Burkey, MD**, received this scholarship in 2007).

Individuals interested in seeking fellowship in the College are encouraged to contact their local ACS Chapter, or **David J. Terris, MD**, chair of the Advisory Council for Otolaryngology—Head and Neck Surgery.

Teaching Facial Plastic and Reconstructive Surgery in Vietnam

Jeffrey R. LeSueur, MD
AAO-HNSF and the Alcon Foundation Resident Travel Grantee

I recently participated in a facial plastic and reconstructive surgery conference in Ho Chi Minh City (formerly Saigon), Vietnam, thanks to a resident travel grant from the American Academy of Otolaryngology—Head and Neck Surgery Foundation and the Alcon Foundation.

As part of a medical team representing the American Academy of Facial Plastic and Reconstructive Surgery's (AAFPRS) FACE TO FACE program, I joined Academy members **Albert J. Fox, MD, Alvin I. Glasgold MD, John M. "Mac" Hodges, MD**, and **Keith A. LaFerriere, MD**.

While there, our delegation performed a variety of surgeries, including facial plastic and reconstructive surgery for congenital and acquired deformities, the aging face, and facial trauma. The intent was to both instruct the local medical teams and provide a much-needed service to the underprivileged.

The hosting facility was the Ho Chi Minh City University of Medicine and Pharmacy under the direction of Nguyen Thi Ngoc Dung, MD, while the procedures were performed at the ENT Hospital of Ho Chi Minh City and Nhan Dan Gia Dinh Hospital. In addition, lectures were given as part of the Facial Plastic Surgery Conference with more than 100 Vietnamese plastic and reconstructive surgeons in attendance.

The relationship between Vietnam and the United States continues to improve as evidenced by Secretary of State Hillary Clinton's multiple visits to the country in 2010.[1] This strategic partnership is further strengthened through programs, such as FACE TO FACE and the Vietnam Education Foundation.

I found the people in Vietnam to be gracious, friendly, and industrious individuals. We all felt a great sense of camaraderie among our surgical colleagues there. While in Vietnam, I realized the truthfulness of the statement: "surgical volunteerism is one of the things that define our profession as a noble one."[2]

I appreciate the AAO-HNSF's continued support of residents and the efforts of the Humanitarian Committee to encourage ongoing volunteerism overseas. Through these experiences, we can recapture our sense of altruism and develop a greater a sense of sympathy—traits that contribute to overall satisfaction and counteract burnout. Can't we all use a little more of that?

References:

1. U.S. Department of State. Remarks by Secretary Clinton: August 2011. Available at: http://www.state.gov/secretary/rm/2011/08/171323.htm. Accessed Dec 19, 2011.
2. Chu, QD, et al. Surgical Volunteerism in Vietnam: Surgeons and Educators Strengthen the U.S. – Vietnam Relationship. Bull Am Coll Surg. 2011 Nov;96(11):12-18.

Nhan Dan Gia Dinh Hospital, Ho Chi Minh City, Vietnam: (L to R): Drs. Thuong T. Nguyen, Jeff LeSueur, John "Mac" Hodges, Albert Fox, and three local Vietnamese surgeons.

2012 Humanitarian Travel Grants: Congratulations to 16 Residents, Thanks to Donors

Thanks to generous support from Academy members who donated to humanitarian efforts, 17 residents and fellows in training received grants of $1,000 each toward medical missions January through July 2012.

For more than a decade, our AAO-HNS Foundation's Humanitarian Efforts Committee has selected senior residents and fellows-in-training for travel grants to accompany mission teams. While the grants of $1,000 each cannot cover the travel costs, the grants are an inspiration to the grantees, who return profoundly changed by their encounters. Feedback from returning residents has demonstrated how valuable these experiences are for both their personal and professional development. Overwhelmingly, they commit themselves to continuing to volunteer for missions.

The 17 awardees will be recognized at the Humanitarian Forum, Sunday, September 9, 2012, 3:30 pm-5:30 pm, at the Walter E. Washington Convention Center in Washington, DC. Please join us in congratulating these residents:

1. **Marcelo B. Antunes, MD**, University of Pennsylvania, Interplast Germany, to Senawad, Madhya Pradesh, India, April 2012.
2. **Melynda A. Barnes, MD**, Stanford University, Children's Rehabilitation Institute and Surgery Program, Mazatenango, Guatemala, February 19-March 2, 2012.
3. **Kavita Dedhia, MD**, University of Pittsburgh, Global ENT Outreach, Phnom Penh, Cambodia, June 1-17, 2012.
4. **Jennifer B. Do, MD**, Kaiser Permanente Medical Center Oakland, Bay Area Surgical Mission, Tigaon, Philippines, January 19-29, 2012.
5. **Michael A. German, MD**, UC Irvine, International Surgical Missions, Catubig, Samar, Philippines, February 4-18, 2012.
6. **Ethan B. Handler, MD,** Kaiser Permanente Medical Center Oakland, Bay Area Surgical Mission, Daet, Camarines, Philippines, February 4-14, 2012.
7. **Karen A. Hawley, MD**, Cleveland Clinic Foundation, Medical Missions

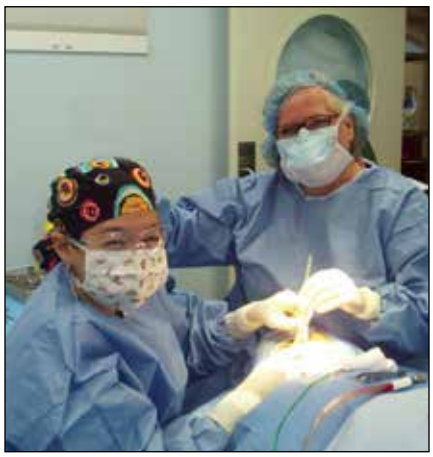
FACE TO FACE team at work in Linyi City, China.

President-elect James L. Netterville, MD, enjoys a gift of dates in Malindi, Kenya.

Dr. Ashley Balaker uses an otologic endoscope to evaluate ear disease in a Cambodian girl.

for Children, City of Angels, Philippines, February 10-20, 2012.

8. **Lauren A. Kilpatrick, MD**, Medical University of South Carolina, Global Smile Foundation, San Salvador, El Salvador, January 21-29, 2012.
9. **Lisa M. Morris, MD**, Oregon Health & Science University, FACES, Lambayeque, Peru, January 20-30, 2012.
10. **Vijay K. Mukhija, MD**, Mount Sinai School of Medicine, Virtue Foundation, Ulaanbaatar, Mongolia, May 7-13, 2012.
11. **Dana K. Petersen, MD**, University of Tennessee, Memphis, Medical Missions for Children, Peru, Cajamarca, June 22-July 1, 2012.
12. **Joseph J. Rousso, MD,** New York Eye and Ear Infirmary, Healing the Children, Northeast, Bangkok, Thailand, February 4-14, 2012.
13. **Melissa A. Scholes, MD**, Nationwide Children's Hospital, Assembly of God, Pediatric ENT Mission to Nicaragua, Managua, Nicaragua, January 21-28, 2012.
14. **Adam M. Terella, MD**, Oregon Health & Science University, FACES, Lambayeque, Peru, January 20-29, 2012.
15. **Patrick C. Walz, MD**, Ohio State University, Project Ear, Los Alcarizzos, Dominican Republic, February 18-26, 2012.



Dr. Esther Cheung-Phillips in the OR. Faith in Practice Mission to Antigua, Guatemala.

16. **Matthew A. Wilson, MD**, University of Utah, Operation Restore Hope, Cebu, Philippines, February 9-19, 2012.

To learn more about humanitarian resident travel grants visit http://www.entnet.org/HumanitarianTravel. May 31 is the deadline for grant applications for July 1-December 31, 2012.

Operation Smile Mission to Accra, Ghana

David A. Gudis, MD
University of Pennsylvania, AAO-HNS Resident Travel Grantee

David A. Gudis, MD, with a young girl about to have surgery for her bilateral cleft lip.

In December 2011, I embarked on a journey to Accra, Ghana, with Operation Smile to be part of a cleft lip and palate surgical mission. I was fortunate to receive the American Academy of Otolaryngology—Head and Neck Surgery Foundation Humanitarian Resident Travel Grant, funded by the Alcon Foundation, and this generous award facilitated a life-changing experience for me.

I had taken part in medical and surgical missions in developing countries before, but had never worked with such a large-scale, highly coordinated effort as Operation Smile. With transportation, accommodation, and meals provided by an impressive network of local public and private partnerships, we could screen more than 200 patients in the first two days of the mission. Our group included seven facial plastic and maxillofacial surgeons from four different countries, and in five days we managed to complete 125 operations. More importantly, the safety standards for each patient and procedure were comparable to our practices at home.

While Ghana has escaped much of the crushing poverty and HIV/AIDS burden of other parts of Sub-Saharan Africa, there remains a tremendous need for healthcare and education. Among the heartbreaking stories I heard was that of a father who was cutting firewood when a small wood chip hit his pregnant wife's belly. A traditional healer confirmed his fear that the trauma caused his infant daughter's torn lip. Ten years later, when his daughter could no longer bear the ridicule she endured at school, she stopped going altogether. When education is critical to breaking the cycle of poverty and poor healthcare, a cleft-lip operation is not a cosmetic procedure; it is a new chance at life.

Patients waiting to hear the surgery schedule.

I originally intended to use the AAO-HNSF grant to return to Cange, Haiti, where I participated in a head and neck surgical mission last year, but the trip was indefinitely postponed because of security concerns. The silver lining was that I had the chance to be a part of this mission in Ghana, which convinced me to incorporate pediatric craniofacial surgery in my future career. I am tremendously grateful to the AAO-HNSF Humanitarian Efforts Committee for the opportunity to be a part of such a moving personal and professional experience.

How the Globalization of Medical Education Has Affected Medical Education in Kazakhstan

James D. Smith, MD
Professor Emeritus, Oregon Health & Science University, Portland, OR

Kazakhstan in Central Asia received its independence from Russia in 1993. Medical education is based on the Soviet system with six years of medical school: three years liberal arts, two years basic science, one year clinical, followed by a one year, mainly observational internship/residency, capped off with several years of probationary work in a hospital under supervision.

My first visit was in 2004, but in 2007, I met Zhaxibay Zhumadilov, MD, vice dean at Semey Medical University, located 90 miles from where the Soviets conducted nuclear tests. Because of his experience with patients suffering from long-term effects of radiation exposure, he has been invited to the United States, where he had an opportunity to observe American medical education.

When he was appointed rector of the Astana Medical University, Dr. Zhumadilov had a vision to improve medical education in Kazakhstan. In 2009, he invited Medical Education International (MEI) to conduct a weeklong course on residency education. He and his faculty had visited the Accreditation Council for Graduate Medical Education (ACGME) website and requested a series of topics about residency education. The course presented American residency training standards, but left ample time for the attendees to discuss what would be useful at their universities.

Multiple-choice questions-writing course attendees take the exam for which they wrote questions.

In 2010, MEI was invited to conduct a weeklong workshop on writing multiple-choice questions (MCQs). My training by the AAO-HNSF on how to write MCQs as a task force member was invaluable. Another team member knew how to evaluate questions for validity and reliability. With this combined experience we produced a credible course that was so well received we were invited back in June 2011. During this visit, we trained others who could then run their own training courses.

This type of trip is not typical of most medical humanitarian trips, but in today's globalization, it is an example of how we can have an opportunity to influence the future of medical education by sharing and interacting with our colleagues in other countries.

Restaurant dinner with hosts and translators. Hosts Drs. Guhar and Lazzat, are at the end of the table. Chris Jenkins, MD, Tulsa, OK, (right), Eric Schackow MD, Chicago, IL (left), and physician-translator (left foreground).

Britain Nepal Otology Service Mission to Nepalgunj, Nepal

Mark Brandt Lorenz, MD
House Ear Clinic, AAO-HNSF
and Alcon Foundation Humanitarian
Travel Grantee

Nepalgunj is a small town in the southwestern Terai province of Nepal, known as one of the poorest areas in one of the world's poorest countries. Streets are densely populated with rickshaws, ox-driven carts, bicycles, motor scooters, and barefoot children. The Britain Nepal Otology Service (BRINOS), www.brinos.org.uk, is a charitable organization that has made humanitarian trips several times a year to Nepalgunj for more than 20 years. BRINOS has treated 39,000 Nepalese patients, has been responsible for more than 4,000 major ear surgeries, and helps provide hearing aids to the local community through trained local otologic assistants who treat patients year-round.

Local children in Nepalgunj.

In November 2011, during our eight-day otologic surgery camp, our group of four surgeons operated on more than 100 major cases. We performed tympanoplasties, mastoidectomies, and stapedectomies under local anesthesia, reserving our limited general anesthetic resources for only the very young. Many patients walked several days to come to our camp, occasionally

Dr. Lorenz team performs ear surgery in Nepal.

barefoot, across hilly terrain. We recruited people from the village to help sterilize instruments and assist with surgery. Patients were always grateful and stoic, despite limited access to pain medication and meager accommodations.

Our team consisted of a surgeon and nurse from England, an anesthetist and nurse from Scotland, and two surgeons from Thailand. Most days were 12-hour efforts, using tents and empty rooms in a local ophthalmologist's facilities. The patients were stoic intraoperatively, and always thankful for our efforts. This experience was a reminder of the privilege and good fortune in my life, reaffirmed the virtue of my clinical efforts, and set a new horizon and decisive direction in my future career. I am thankful that the AAO-HNSF Humanitarian Efforts Committee and Alcon Foundation provided funds for my trip, and guided me toward this productive and meaningful organization.

Father and son after tympanomastoidectomy.

ENT Medical Mission Trip to Riobamba, Ecuador

Karina T. Canadas, MD
Resident Travel Grantee, Yale-New Haven Hospital/Yale University School of Medicine

Our first mission trip to Riobamba, Ecuador, with YHB charitable endowments and Clinica Dulce Refugio, was a great success. We were a 13-person team of ENT physicians, general surgeons, anesthesiologists, pediatricians, scrub techs, and nurses, led by Howard P. Boey, MD. Together, we provided ENT and general surgery care to the indigent population of the region at the Military Hospital of Riobamba, Ecuador, November 4-12, 2011.

Brad Jubelirer, MD, with cleft palate patient in PACU.

Nestled in the Andes Mountains between active volcanoes, Riobamba is a small city located 125 miles south of the capital of Quito. The area does not have surgical subspecialties, particularly ENT, readily available to its community. With an average household income of $160 per month, there are numerous barriers to accessing appropriate healthcare.

In five days our group performed 58 surgeries on children and adults, 30 of which were ENT cases. Surgeries performed include thyroidectomies, cleft palate and nose repair, velopharyngeal insufficiency repair, septoplasties, tonsillectomies, adenoidectomies, and facial scar revisions. Our target population, in addition to the locals, included the indigenous population, the Shuar, who live nearby in the Amazon forest.

Unfortunately, we could not help everyone. Such cases included three cleft lip and palate patients who weighed less than five kilos and were deemed too high an operative risk given the lack of appropriate local anesthesia equipment. One of these kids, a six-month-old with bilateral cleft lip and palate, I'll never forget. He and his family were of the Shuar Indians and they traveled three hours, including two hours by foot, just to see us. Although the local foundation arranged for another medical mission trip to treat him in the near future, it was a frustrating feeling knowing you could not immediately help a patient, but it provided motivation to return after additional preparation.

Overall, it was a wonderful experience. We had an immediate and lasting influence on the community, and everyone was incredibly thankful. Many even offered us the local delicacy of cooked guinea pig as a sign of gratitude. I tried to bring a little piece of this for the AAO-HNSF Humanitarian Efforts Committee and the Alcon Foundation as a sign of my gratitude for their support in funding me, but customs stopped me. I would definitely recommend this trip to anyone interested.

"In five days our group performed 58 surgeries on children and adults, 30 of which were ENT cases."

ENT and PACU team with post-op adenoidectomy patient: Howard Boey, MD (left)., Shauna Bartlett, Karina Canadas, MD (right).

COASTAL NORTH CAROLINA PRACTICE OPPORTUNITY

Well established regional Otolaryngology practice is seeking a BC/BE Otolaryngologist. In its fourth decade, this four physician group has three office locations serving Eastern North Carolina.

Practice includes full audiology and allergy services with CT scanner, EMR, and operating/laser suite. Three audiologists and a strong support staff are in place to support further practice growth. All aspects of Otolaryngology are practiced and specialty interests in laryngology, head & neck oncology or facial plastics can be easily integrated into existing practice.

Coastal Eastern North Carolina is a beautiful region rich in history and offering abundant access to local rivers and sounds as well as various beach communities along North Carolina´s Outer Banks.

Interested applicants should contact:

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830 Washington Street, Watertown, NY 13601

Northern California ENT and Otology Opportunities

Sutter Health is one of the nation's leading non-for-profit networks whose health care providers join resources and expertise to deliver care to patients in over 100 Northern California communities.

Current opportunities include: Auburn - Establish a practice with Sutter Medical Group (SMG) or Sutter Independent Physicians (SIP) affiliated with Sutter Auburn Faith Hospital (SAFH). SAFH is an 80-bed community based hospital with a service area of 95,000. **Vacaville** - Join Sutter Medical Group (SMG), affiliated with Sutter Solano Medical Center (SSMC) and Sutter Davis Hospital (SDH). SSMC has 102 licensed beds, is among the top hospital in the region according to independent quality rating organizations. SDH is a 48-bed acute care hospital that provides convenient, quality care. **Sacramento** – Join SMF affiliated with Sutter Medical Center, Sacramento (SMCS). SMCS has more than 400 licensed beds at three facilities: Sutter General Hospital, Sutter Memorial Hospital and Sutter Cancer Center for Psychiatry.

SMG is a multi-specialty, 600+ physician group in the Placer, Sacramento, Solano, and Yolo Counties, recognized as a Top Performing group by the Integrated Healthcare Association. **SIP** is an independent practice association comprised of 500+ physicians throughout the Placer, Sacramento, Solano and Yolo counties.

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40 N. Grand Avenue, Suite 103, Fort Thomas, KY 41075
Phone: (859) 572-3046, Fax: (859) 572-3045, Email: sarahg@nkyent.com

ACADEMIC
HEAD & NECK SURGEON
West Virginia University

The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to expand our well established head and neck oncology service. Expertise with both ablative and microvascular reconstructive procedures is desired. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

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

West Virginia University is located in beautiful Morgantown, which is rated one of the best small towns in America in regard to quality of life. Morgantown is located 80 miles south of Pittsburgh and three hours from Washington, DC. The position will become available in October 2011 and will remain open until filled. The WVU Health Sciences Center is a smoke free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

Contact:
Hassan Ramadan, MD
Department of Otolaryngology
R.C. Byrd Health Sciences Center
Morgantown, WV 26506-9200
Telephone: (304) 293-3233; Fax: (304) 293-2902
e-mail: hramadan@hsc.wvu.edu
West Virginia University is an EOE/AA employer.

OTOLOGIST / NEUROTOLOGIST

Seeking an experienced, fellowship-trained otologist/neurotologist to replace a retiring senior partner at the world-renowned Shea Ear Clinic in Memphis, TN. The **Shea Ear Clinic** was founded in 1926 and is a tertiary referral otologic clinic that specializes in the treatment of all diseases of the hearing and balance system, including chronic otitis media, stapedectomy, cochlear implantation, and inner ear perfusion. We are an extremely successful and innovative four-physician private practice with our own outpatient surgery center and hearing aid center. We currently have three otologists and one general otolaryngologist. Our state of the art audiology department has three Aud's and one audiology tech. Clinical appointments are available at the University of Tennessee Department of Otolaryngology – Head and Neck Surgery and teaching of residents is encouraged. Major procedures such as acoustic neuromas are performed at one of several large local hospitals.

Extremely competitive salary and benefits plus fast track to partnership, generous signing bonus, and relocation package. Memphis is a major regional medical center that serves patients from the mid-south and beyond. Memphis offers a laid-back lifestyle with a low cost of living and small town southern hospitality, but big-city amenities, professional sports, good schools, and many cultural attractions.

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Southern New Hampshire Otolaryngology Group Seeks Fourth Physician

Three established physicians who appreciate hard work, enthusiasm and the highest quality of medical care are looking for a BC/BE Otolaryngologist who shares the same values.

Manchester, New Hampshire is conveniently located one hour from Boston, the seacoast and the White Mountains. New Hampshire is known for its excellent skiing, hiking, biking and fishing. Its beautiful lakes broaden the appeal to those who enjoy an active outdoor lifestyle set in a temperate four-season climate.

Money magazine has named Manchester, NH as the top small city in the Northeast. It boasts low unemployment, low crime rate and is a wonderful city to raise a family. New Hampshire is unique for having no sales or income tax and has the highest qualities of living in the nation!

Southern New Hampshire continues to grow at a rapid pace, therefore affording us the opportunity to expand. Our physicians have worked hard to earn the respect of the community and are held in the utmost regard.

We offer a 2 year partnership tract, competitive salary with incentive bonus and a very generous benefit package including 401K and profit sharing.

To learn more about our group, please visit our website: www.entspecialistsnh.com or contact Heather Rice, Hrice@entspec.org

Ear Nose & Throat Specialists of Southern New Hampshire, PA
30 Canton Street, Suite Two
Manchester, NH 03103 • (603)656-2100

BC/BE OTOLARYNGOLOGIST

Geisinger Medical Center (GMC) in Danville, PA is seeking a BC/BE fellowship-trained Head & Neck Otolaryngologist with special interest in Endocrine Surgery

Bring your expertise to an established, growing practice at Geisinger Medical Center – Danville, PA. This practice opportunity is pre-built with a broad-range of referrals coming from community-based primary care physicians. Take part in the growth of this dynamic department, teach residents and pursue research in your area of interest.

For more information or to apply for this position, please contact Autum Ellis, Professional Staff Recruiter, at 1-800-845-7112, email amellis1@geisinger.edu or learn more at Join-Geisinger.org

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HEALTH SYSTEM
REDEFINING THE BOUNDARIES OF MEDICINE

Join the health system whose innovations are influencing the future of healthcare. Learn more at **Join-Geisinger.org**

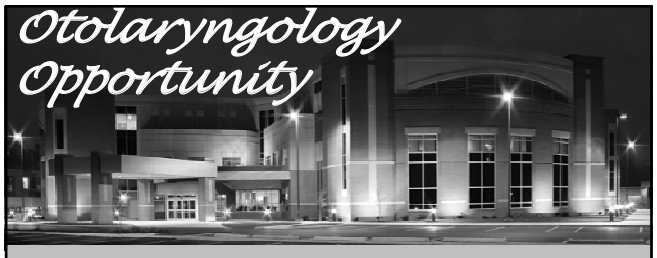
Opportunity in Portland, Maine

An excellent opportunity has just become available in Maine's largest city, Portland. MKM / ENT Associates, an established practice with an impeccable reputation is seeking an additional Otolaryngologist. This full service practice is currently comprised of 3 physicians and a physicians assistant, along with 3 audiologists, a speech pathologist, two physical therapists and outstanding support staff. The practice, which is the largest in the State, has an active cochlear implant program, hearing aid services, an integrated balance center and speech lab. This represents a well rounded general practice with opportunities to pursue and develop subspecialty interests. The call is presently 1 in 8 and is shared city wide. We offer a competitive base salary with productivity incentives, malpractice, vacation, CME, assistance with medical debt, relocation expenses, and full fringe benefits package.

MKM/ ENT Associates is part of Mercy Hospital, a progressive 170-bed community hospital serving the greater Portland area. The physician will benefit from referrals from within Mercy's robust primary care network as well as statewide and regionally. Mercy Health System has 30 primary and specialty care practices.

With a metro population of 300,000+, the Greater Portland area is home to one quarter of Maine's total population. Portland itself is a cosmopolitan and comfortable small city with a population of 64,000. The Greater Portland area has more than 35 miles of trails to hike, jog or cross-country ski. It is just minutes from beautiful coastal sandy beaches and less than an hour to mountains for winter skiing. Portland is also a modern city filled with galleries, one-of-kind boutiques and shops, theater, music, and sports teams. It boasts more restaurants per capita than any city of its size on the eastern seaboard and is a "foodie destination". There are a variety of educational options, both private and public and Maine is recognized as one of the best places in the country for children.

Find the perfect work-life balance combining a satisfying and challenging Otolaryngology practice while living in a safe and beautiful community rich in cultural and recreational options.



Elkhart, Indiana

Elkhart General Healthcare System *is assisting in the recruitment of a* ***BC/BE Otolaryngologist*** *to expand services within the community.*

- Participate in 1:4 ER call
- Open to surgeons desiring a general or subspecialty practice
- Draw area of 250,000, Elkhart General Hospital's services include Sleep Disorders Center, Regional Center for Cancer Services, comprehensive diagnostic imaging services that include the **region's first 128-slice CT scanner,** as well as an ICANL certified Nuclear Medicine laboratory
- Call demands minimized by Hospitalist program that will soon provide 24/7 coverage
- Conveniently located 30 minutes to South Bend and Goshen, Elkhart is within two hours of Chicago
- Population 55,000, Elkhart has a vibrant downtown retail and restaurant district, beautiful greenscapes along the St. Joseph River, extremely affordable housing options, along with excellent public and private schools
- 13 schools of higher education are the region, including The University of Notre Dame, St. Mary's College, and Goshen College

To Inquire, Contact:
Pam Buckalew, Search Consultant Coordinator
(800) 528-8286, extension 4102
pam.buckalew@stratummed.com

Elkhart General
Healthcare System

OTOLARYNGOLOGIST

Geisinger Health System is seeking a BC/BE Otolaryngologist

Bring your expertise to a well-established program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA. Take part in the growth of this dynamic department, teach residents and pursue research in your area of interest.

Visit **Join-Geisinger.org/266/OtoGWV** to learn more about this position or contact Autum Ellis, Physician Recruiter, at 1-800-845-7112 or amellis1@geisinger.edu.

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Join the health system whose innovations are influencing the future of healthcare. Learn more at **geisinger.org/national.**

Successful Otolaryngologist

Dr. Gordon Strothers is retiring

Recruiting a Partner for
New Haven area ENT group

Contact:
K.J. Lee
MD, FACS
kjleemd@aol.com
Telephone: 203-777-4005
Fax: 203-776-7741

Dedicated to physicians who are dedicated to children.

Join our Pediatric Otolaryngology team in Pensacola, Florida.

As one of the premier pediatric health care systems in the nation, Nemours has made a promise to do whatever it takes to prevent and treat even the most disabling childhood conditions. That's why we're pioneering technology such as the fully integrated electronic medical record (EMR) and innovative new techniques like minimally invasive and robotic surgery. And why we attract some of the country's top pediatric physicians.

Our opening for a Pediatric Otolaryngologist offers:

- A 100% pediatric case mix
- Excellent benefits and relocation packages
- Available academic appointment
- A beautiful coastal lifestyle
- Research opportunities

For information, contact Brian Richardson, Physician Recruiter at 407-650-7670 or brichard@nemours.org.

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NORTHWEST HOUSTON OTOLARYNGOLOGIST

Busy, stable general otolaryngology private practice in NW Houston seeks a board certified or board eligible Otolaryngologist to join our group. All facets of otolaryngology are covered at this facility, including an allergy lab, hearing aid lab, VNG and sleep lab. Practice consists of three otolaryngologists (two full time board certified with one subspecialty board certified in sleep medicine & one part-time) and two audiologists. Practice has two locations in medical professional buildings. Demographic base of more than two hundred thousand patients in vicinity of nearby hospital and half a million patients in general NW Houston area.

Interested physicians should contact

Don Unfried at **281-732-9770**

or email at **donunfried@hcstexas.com**

General Otolaryngologist

POSITION NUMBER: M0202609

The University of Kansas Otolaryngology-Head & Neck Surgery Department is seeking a General Otolaryngologist to join a faculty of 15 physicians. The successful candidate will develop a practice at The Kansas University Medical Center and affiliated hospital sites and teach residents & medical students.

Head and Neck Surgeon

POSITION NUMBER: J0010781

The University of Kansas Otolaryngology-Head & Neck Surgery Department is seeking a BC/BE Head and Neck Surgeon for a full-time academic position. Fellowship training with expertise in microvascular surgery and an interest in oncologic research preferred.

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

Head and Neck Fellow

POSITION NUMBER: J0020146

CLINICAL FOCUS

Head and Neck Surgical Oncology, Skull Base Surgery (anterior and lateral), Minimally Invasive Endoscopic Laser Surgery, Minimally Invasive Endocrine Surgery, Microvascular Reconstructive Surgery

Responsibilities will include clinical activities, clinical/basic science research, and resident and medical student teaching. Additional educational opportunities include a graduate level Clinical Research Training series, access to a microvascular laboratory, a craniomaxillofacial plating course and clinical research support personnel.

APPLICANT REQUIREMENTS

Successful completion of an ACGME-accredited Otolaryngology-Head and Neck Surgery Residency training program, ABO board certified/eligible and Kansas and Missouri license eligible.

KU UNIVERSITY of KANSAS Department of Otolaryngology Head & Neck Surgery

To view position online:

http://jobs.kumc.edu

(Search by Position Number)

For job information or to apply, contact:

Douglas Girod, MD, FACS
Professor and Chairman

The University of Kansas
School of Medicine
Department of Otolaryngology-
Head & Neck Surgery
3901 Rainbow Blvd. MS 3010
Kansas City, KS 66160

Phone: 913-588-6719
Email: dgirod@kumc.edu

The University of Kansas School of Medicine is an Equal Opportunity/ Affirmative Action employer.

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 their clinical/academic programs and recruiting a full-time, board certified **Otolaryngologist with a background and experience in adult and pediatric otologic patient care including cochlear implantation.**

This position requires a strong interest and commitment to the education of residents, fellows and medical students. Academic appointment will be commensurate with experience/qualifications. MD degree and the obtainment of a permanent Ohio medical licensure required.

Interested candidates should send a letter of interest, CV and a list of three references to:

www.jobsatuc.com

--The University of Cincinnati is an equal opportunity and affirmative action employer--

University of Missouri

Department of Otolaryngology—
Head and Neck Surgery

Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. A Faculty opportunity at all academic levels (Assistant/Associate Professor or Professor or Clinical Assistant/ Associate Professor or Clinical Professor) is available in **Head and Neck Surgical Oncology**. 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 this position, please visit the MU web site at hrs.missouri.edu/find-a-job/academic/

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

Division Chief, Pediatric Otolaryngology - Head and Neck Surgery

Nemours Children's Clinic, Jacksonville, FL

We are seeking candidates for this full-time position who possess strong leadership and interpersonal skills and who demonstrate collaborative communication. The candidate should have a strong record in pediatric clinical care and education, as well as the ability to shape annual divisional objectives and plans and to manage the support of these goals. The division currently consists of 6 full-time fellowship-trained physicians, 5 audiologists, 4 speech pathologists and 1 Ph.D. researcher within a 70+ physician pediatric subspecialty practice. Complete ancillary services are available on-site. The practice is 100% pediatric case mix and serves children from Southeast Georgia and Northeast Florida. An opportunity for an academic appointment to the Mayo Clinic College of Medicine is available. Nemours offers a competitive salary and a full array of benefits.

Jacksonville is on the northeast coast of Florida. It is bordered by the Atlantic Ocean, and the St. Johns River travels through the city, offering wonderful water views. We have wonderful weather all year-round, allowing outdoor activities and water sports to be enjoyed during personal time.

For further information, please contact: **Gary D. Josephson, M.D., Office: 904-390-3690, Cell: 904-226-1231 or gjosephs@nemours.org. Nemours Children's Clinic, 807 Children's Way, Jacksonville, FL 32207**

Nemours, an Equal Opportunity Employer, is one of the nation's largest pediatric subspecialty practices operating the Nemours Children's Clinics throughout Florida and Delaware and the Alfred I. duPont Hospital for Children in Wilmington, DE.

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mainecoast memorial hospital

OTOLARYNGOLOGIST OPPORTUNITY

Maine Coast Memorial Hospital, Ellsworth, Maine, is seeking an additional Board Certified or board eligible Otolaryngologist. The physician can look forward to a strong referral pattern and existing patient base. A well-run small community hospital, MCMH provides an excellent environment for a busy Otolaryngology practice. In addition, the physician will be able to walk into a fully equipped office and will enjoy an experienced surgical staff. Surgery is on the hospital campus in both an inpatient or outpatient setting. As a smaller hospital, ER call is light with minimal trauma. Excellent salary, benefits, vacation and CME. Signing and relocation bonuses are available, along with medical education loan reimbursement.

MCMH is committed to serving our patients with excellence in healthcare. The Ellsworth community is nestled on the scenic Maine coast and is surrounded by Acadia National Park with mountains and exceptional year-round recreation including hiking, biking, fishing, hunting, boating, skiing, golf and more. Our neighborhoods are safe, family friendly and have outstanding schools.

Please send your CV to:
Maine Coast Memorial Hospital
Heather Fowler, Physician Recruiter
50 Union Street, Ellsworth Maine 04605
Phone: (207) 664-5314
Fax: (207) 664-5452
Email: hfowler@mainehospital.org

www.mainehospital.org

Maine Coast Memorial Hospital is an equal opportunity employer.

Full Time Faculty Opportunities
University of Rochester Medical Center

Laryngologist
BC/BE, fellowship trained or equivalent experience laryngologist at any rank is sought to help build a nationally prominent laryngology and voice practice. Applicants should have a strong interest in clinical care and academic teaching. Protected research time and resources are available if candidate seeks a career as a clinician-scientist.

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

General Otolaryngology
BC/BE otolaryngologists with broad clinical interests are sought to develop a general otolaryngology practice in a community setting with full academic support. Protected research time and resources are available for clinician-scientists.

Our robust clinical practice and training program is affiliated with the University of Rochester Medical Center's Strong Memorial Hospital. The clinical office is located in a new facility opened in 2004. These are excellent opportunities to practice with an established group of academic faculty who already have practices in all Otolaryngology subspecialty areas, in a growing academic department.

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

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

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

Pediatric Otolaryngology - Academic Position

The Department of Otorhinolaryngology is recruiting a third Pediatric Otolaryngologist to join a busy, tertiary Pediatric Otolaryngology practice. This is a unique opportunity to join a rapidly growing Department at a major University Children's Hospital with a large Level III NICU and a Level I Trauma Center. Excellent compensation and benefits. Academic appointment commensurate with experience. Strong interest in resident and medical student teaching and research is encouraged.

Applicants should forward a CV and statement of interest to:
Soham Roy, MD, FACS, FAAP
Director of Pediatric Otolaryngology
The University of Texas Medical School at Houston
Department of Otorhinolaryngology-Head & Neck Surgery
713-383-3727 (fax)
Soham.Roy@uth.tmc.edu
http://www.ut-ent.org

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

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12TH ANNUAL

Charleston Magnolia Conference

JUNE 1 - 2, 2012

– GUEST SPEAKERS –

John W, House, MD
President, House Research Insititute
Los Angeles, CA

John S. Rhee, MD, MPH, FACS
John C. Koss Professor and Chair
Department of Otolaryngology & Communication Sciences
Medical College of Wisconsin, Milwaukee, WI

James D. Sidman, MD
Chief, Otolaryngology Department
Children's Hospital - Minneapolis, MN

– TOPICS –

• Endoscopic Sinus Surgery • Pediatric Sleep Apnea
• Endoscopic and Robotic Head and Neck Cancer Surgery
• Management of Cholesteatoma
• Management of Ear Canal Infections
• Functional Rhinoplasty • Sleep Surgery • Endocrine Surgery

– RECREATION –

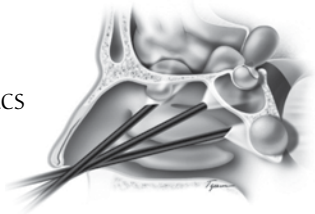
Beaches | Golf | Historic Charleston | Spoleto Arts Festival USA

MUSC MEDICAL UNIVERSITY of SOUTH CAROLINA

Otolaryngology – Head & Neck Surgery
Contact: 843-792-8238 • Email: padlangi@musc.edu
http://ENT.musc.edu

May 18 - 19, 2012 • New York City

Advanced Endoscopic Skull Base and Pituitary Surgery



COURSE DIRECTORS:
Vijay K. Anand, MD, FACS
Theodore H. Schwartz, MD, FACS

GUEST FACULTY:
John Jane Jr., MD
Charles Teo, MD

2-DAY COURSE DESCRIPTION: This course is a comprehensive overview of the newly emerging field of endoscopic skull base surgery combining didactic sessions with hands-on cadaver dissection. At the completion of this course, participants should be well equipped to start utilizing these approaches in their own practices. Endoscopic instruments and surgical navigation equipment will be available to participants for use on fresh cadavers during laboratory sessions. Participants will have an opportunity to discuss difficult cases with the faculty during panel discussions. Early registration is highly recommended.

LOCATION: Weill Cornell Medical College
1300 York Avenue, New York, NY 10065

INFORMATION: Course Coordinator
Tel: 212-585-6800
email: jeg9059@nyp.org
www.cornellneurosurgery.org

Weill Cornell Medical College

NewYork-Presbyterian
Weill Cornell Medical Center

Southern States Rhinology Course

An Evidence Based, Interactive, Hands On Learning Experience

May 3 - 5, 2012 Kiawah Island Golf Resort, Kiawah Island, SC

Course Topics:
- Evidence Based Panels on Medical and Surgical Management of CRS
- Difficult Frontal Sinus Cases, Pediatric CRS, and ESS Failures
- The Role of Balloon Sinuplasty
- Consult the Experts Panel

Cadaver Lab
A hands on laboratory dissection is also available with this course. Participants will have the opportunity to dissect cadaver specimens featuring state-of-the-art endoscopic instrumentation, video, and image guidance system

Faculty:
- John DelGaudio, MD - Emory School of Medicine
- Frederick Kuhn, MD - GA Nasal & Sinus Institute
- Stil Kountakis, MD - Georgia Health Sciences University
- Rodney Schlossler, MD - Medical University of SC
- Brent Senior, MD - UNC School of Medicine
- Michael Sillers, MD - Alabama Nasal & Sinus Center

Scan the QR Code directly from your smartphone for full meeting details and Registration or visit www.southernstatesrhinology.org

Save the date!

AAO-HNSF Annual Meeting & OTO EXPO 2012 September 9-12 WASHINGTON, DC

AAO-HNSF 2012 Annual Meeting & OTO EXPO

Some Dates to Remember:

Online Registration & Housing
Opens May 2012
Register early to save up to 50%

Instruction Course & Miniseminar
Notification: March 2012

Scientific Program (Oral & Poster)
Notification: April 2012

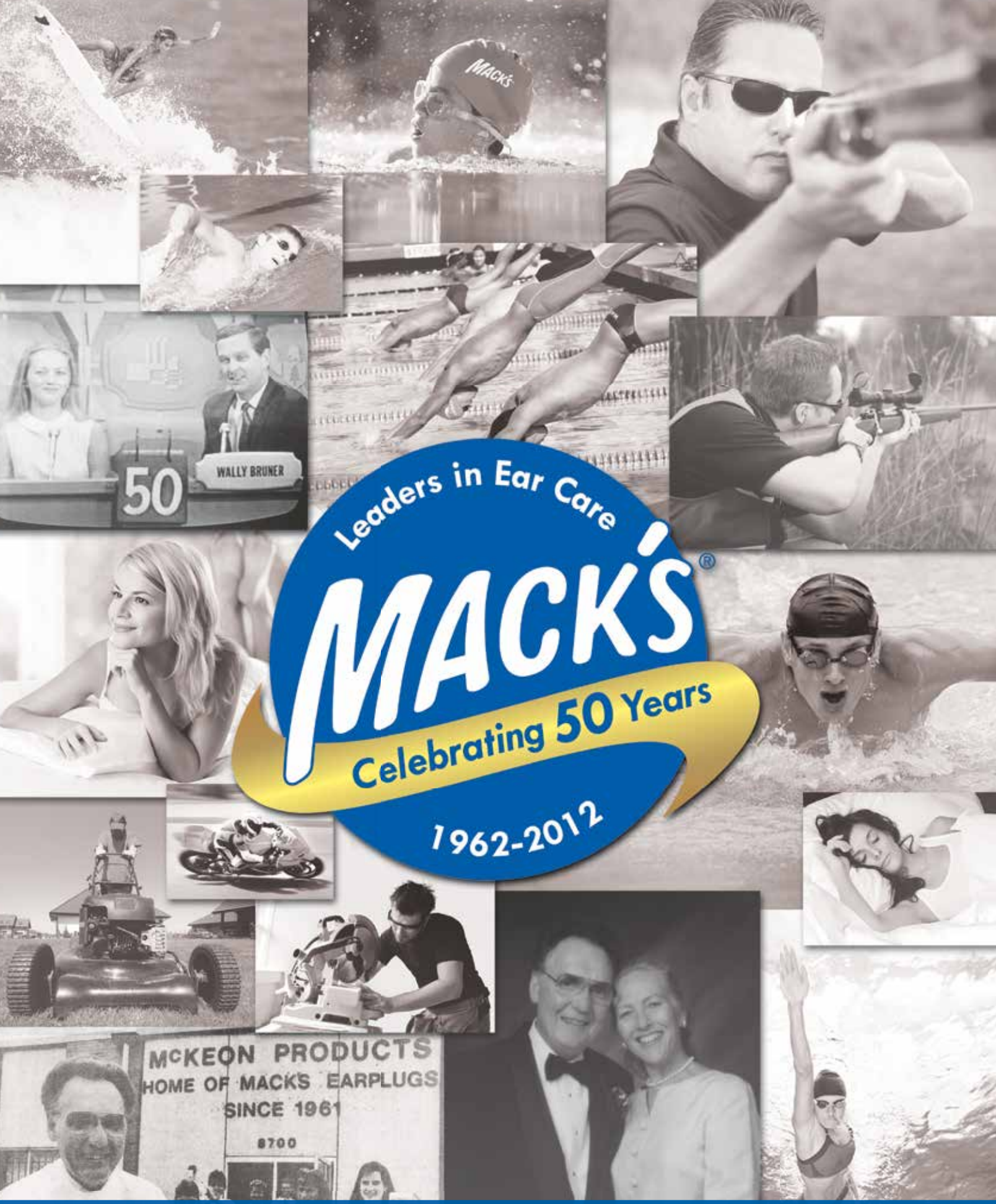
Explore the Nation's Capital
Experience fascinating, free attractions and festive events that make Washington, DC a favorite destination for travelers worldwide. While attending the AAO-HSNF Annual Meeting & OTO EXPO, be sure to explore D.C.'s inspiring museums, powerful monuments, and spectacular memorials.

Visit **www.entnet.org/annual_meeting**

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

Empowering otolaryngologist—head and neck surgeons to deliver the best patient care

1650 Diagonal Road, Alexandria, Virginia 22314-2857 U.S.A.



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www.macksearplugs.com