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The official member magazine of the **American Academy of Otolaryngology—Head and Neck Surgery**

FEBRUARY 2016

We care for kids

General otolaryngologists can successfully treat the majority of ENT-related pediatric diseases. **20**

Updated Clinical Practice Guideline: **Otitis Media With Effusion** **14**

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

INQUIRIES AND SUBMISSIONS
bulletin@entnet.org

MAILING INFORMATION
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Ascend Integrated Media, LLC
Suzee Dittberner
6710 West 121st St., Ste 100
Overland Park, KS, 66209
Phone: 1-913-344-1420
Fax: 1-913-344-1492
sdittberner@ascendintegratedmedia.com

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The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) is the world's largest organization representing specialists who treat the ear, nose, throat and related structures of the head and neck.

Specialization or fragmentation?

Who are we as otolaryngologists? We are physicians (MDs and DOs) trained to take care of medical and surgical problems of the ear, nose, throat, head, and neck. The American Board of Otolaryngology's (ABOto) primary certificate qualifies us to practice "otolaryngology including general otolaryngology, otology, facial plastic surgery, head and neck surgery, and pediatric otolaryngology."

READ MORE ONLINE
References available

Why, then, specialization? In the April 2011 *Bulletin*, **Michael D. Seidman, MD**, and **Brian J. Broker, MD**, weighed in with a very thoughtful piece on this subject. Specialization's benefit is the ability to advance knowledge and care of difficult or challenging clinical scenarios while targeting research. However, there is a risk of fragmentation of an already small field that then loses the ability to care for the overall population effectively. The concept of "focused expertise" certification has surfaced, and the American Board of Medical Specialties (ABMS) has sought comments from specialty boards and associations regarding this potentially divisive issue. The AAO-HNS responded to the ABMS with concerns that this proposal could further diminish surgical opportunities for resident otolaryngologists as well as other specialties and exacerbate concerns about the level of preparedness to enter practice following completion of a residency. We feel this will serve to further confuse the public and referring physicians as to which physicians should be managing various diseases. We also feel that it is certain to further divide the specialty much in the way that the current controversy over pediatric subspecialization has.

The ABOto and the AAO-HNS have consistently promoted the otolaryngologist's qualifications and expertise to treat patients with disease processes as described on their board certificate. When the American Academy of Pediatrics (AAP) chose to single out pediatric otolaryngologists as the most appropriate group to treat children's ENT disorders, on their consumer website, **James C. Denneny III, MD**, AAO-HNS/F EVP/ CEO, and I sent a letter to the AAP, asking them to modify their recommendations, pointing out that all otolaryngologists can treat common pediatric problems very effectively and that 400 pediatric otolaryngologists cannot effectively cover the general ENT care of 74 million American children.

Roughly one-third of general ENT practice is pediatric. A sizeable minority of specialty ENT practice, particularly otology, is also pediatric. Twenty percent of adult and 50 percent of pediatric primary care visits are for otolaryngologic complaints. Common pediatric ENT problems include, but are not limited to, acute otitis media, otitis media with effusion, tonsillitis, adenoiditis, rhinitis, and laryngotracheobronchitis. We would all agree that the vast majority of these cases can be managed safely and effectively by a properly trained general otolaryngologist.

As otolaryngologists, we are physicians who are all highly trained in the ear, nose, throat, and neck care of children and adults. We are a small specialty, but because nearly everyone has had an ENT illness at one time, and because our staff is so diligent on Capitol Hill and in the media, we have a disproportionately loud voice. General ENTs can provide much of otolaryngologic care. Specialty ENTs should take care of those patients whose ENT issues or overall health circumstances make their cases complex. Establishing a true synergy between general and specialty otolaryngology will keep our profession strong and growing.

Benjamin Franklin said, "We must all hang together or, assuredly, we shall all hang separately." In 1751, to support the creation of Pennsylvania Hospital, he said, but "the Good particular Men may do separately, in relieving the Sick, is small, compared with what they may do collectively, or by a joint Endeavour and Interest." Our joint endeavor—our ability to hang together—is the AAO-HNS, which wields power to effect change in media and public perception, and influence policy decisions. This unity benefits general and specialty otolaryngologists, and all of our patients, by allowing us the opportunity and freedom to practice the spectrum of otolaryngology our expertise justifies.

Sujana S. Chandrasekhar, MD
AAO-HNS/F President

> "All otolaryngologists can treat common pediatric problems ... 400 pediatric otolaryngologists cannot cover the general ENT care of 74 million American children."

See also "We care for kids," page 20.

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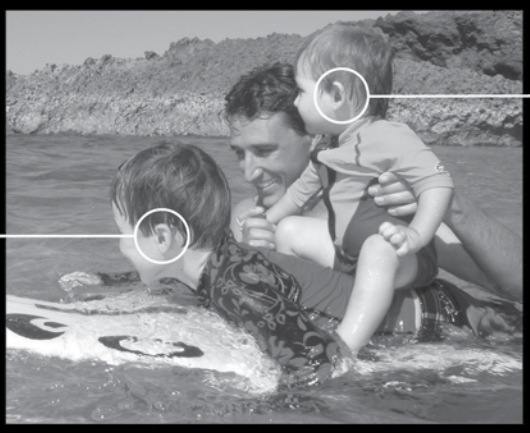

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We support you

Having just completed a series of comment letters to various government agencies that took weeks to construct and considerable staff time to adequately address all of the issues currently faced by our Members, it drove home the point that the extreme complexity woven into the delivery system is taking away the "joy of practicing medicine" from physicians across the house of medicine. During recent travels through airports in various parts of the country, I have overheard conversations from physicians in primary care, medical specialty care, and surgical specialty care all bemoaning the fact that not only are additional requirements being added in a rapid continual fashion, but the enjoyable parts of practicing medicine are additionally being diminished inexorably. To listen to "veterans" of medical practice across the board discussing ways to get out of practice as soon as possible is discouraging to say the least.

Among the most important points made in our comment letters, were the facts that the system needs to be simplified and made easy to understand, and the continued uncertainty needs to be resolved. We've also repeatedly advocated that otolaryngologists as well as other specialists need to have the realistic opportunity to participate equally in all of the programs available to physicians in the Medicare system.

It has become quite clear that CMS is not expecting the vast majority of physicians to be able to participate in the Alternative Payment Model (APM) program. We have expended and will continue to allocate considerable resources searching for applicable models otolaryngologists can utilize to be part of the APM program, but the program as it is written makes it much less likely to succeed than to fail and that is unacceptable in my opinion. There is considerable activity and concern in the medical community working to change the trajectory of the current plan.

You, our Members, are busy taking care of patients. We feel it is our job to take care of you so you can accomplish your mission of providing the best care. We are very sensitive to the value proposition that our Members expect from us. It is difficult to quantify a precise value that can be attributed to governmental and regulatory advocacy as well as private payer advocacy, production of quality metrics for reporting purposes, and work in the CPT/RUC arena, but a conservative estimate would be well into five figures. We recently analyzed our spending for critical Member services and found that we spent roughly $1,125 per Member, while the average dues revenue across all membership categories was $600. This figure did not include costs for the registry we are in the process of instituting. We continue to look for ways to prioritize programs and maximize value across the spectrum of our specialty.

We continue to make rapid progress on the registry and anticipate the pilot program to commence early in the new year. Considerable work was done by our staff in getting our application materials and procedures for a Qualified Clinical Data Registry (QCDR) ready by the January 31 CMS deadline. With the help of the Large Group Forum and Louise Eddy, MS, CCC/A, FAAA, we are working on completing the Regent℠ "data dictionary," which houses all of Regent's measures and data elements, to have it ready for commencement of the pilot. This tedious and complex process has required considerable, focused effort on the part of our Quality and Health Policy business unit headed by its Senior Director Jean Brereton, MBA. We will have had a significant response to participation both in the Regent pilot as well as the registry once it launches for full participation in the summer. We have identified and selected 35 sites for the pilot and began contracting with each site in January. The Foundation Board of Directors recently approved the governance structure for the registry, which will include representation from private practice, academic practice, the American Board of Otolaryngology, and specialty societies representing the spectrum of clinical practice in otolaryngology. We now have named members to the Executive Committee of Regent as well as begun the process of populating the seven Advisory Committees representing the clinical disciplines that will be included in the registry. The Executive Committee will be the governing body responsible for operations including policies and procedures addressing registry content, research, analytics, and monitizing of its products and data.

The apparent realization that most specialty providers will be participating in the Merit-Based Incentive Payment Systems (MIPS) arm of the Medicare payment system will make the creation of measures applicable across the broad clinical expertise reflected in the practice of otolaryngology critical to our Members both in the government and private payer systems. The inclusion of our specialty societies as partners will help us achieve these goals much more rapidly. ■

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

"You, our Members, are busy taking care of patients. We feel it is our job to take care of you so you can accomplish your mission of providing the best care."

Leadership Forum & BOG Spring Meeting: *the* place to be in March

The AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting is a weekend of leadership discussions, Board of Governors (BOG) meetings, informative speakers, coding workshops, advocacy updates, and mentoring/networking opportunities. This meeting is one of many AAO-HNS benefits, allowing Members the opportunity to engage in peer-to-peer interaction and network with eminent leaders. The event is free for AAO-HNS Members who are otolaryngology practitioners, although registration is required.

Join your colleagues Friday, March 18, through Monday, March 21, at the Westin Hotel in Alexandria, VA, for:

- **Advocacy sessions:** Via a role-playing exercise, become more comfortable speaking with lawmakers regarding legislative issues impacting the specialty.
- **Leadership development and practice tips:** Build your leadership skills while learning practical tips not taught in medical school.
- **Speed mentoring:** Mentees can seek guidance and learn from others' experiences while mentors can positively influence the future in this interactive session.
- **BOG General Assembly:** Observe your Board of Governors in action and learn more about its grassroots role for the Academy. Ask questions at the President-Elect Candidates Forum to learn more about the Members running for president in the 2016 AAO-HNS election.
- **A trifecta of keynote luncheon speakers:** Hear from renowned leaders on diversity, leadership, and the 2016 U.S. federal elections.
- **ICD-10 issues and solutions:** Gain a better understanding of ICD-10 coding to overcome challenges for your practice.
- **Society representation at its best:** Learn how to "bring home the Academy" to your state or local society.
- **Content designed for Residents & Fellows-in-Training and Young Physicians:** Gain critical knowledge and information to help you grow at this formative stage in your career.
- **mENTorConnect Reception:** Have some fun at a unique "scavenger hunt" event.
- **ENT PAC Reception:** Always a favorite, gather with fellow PAC supporters for political conversation and some healthy competition (ENT PAC Leadership Club members only).
- **Coding and Practice Management Workshops:** Build your coding and business practice skills in your choice of one, two, or three sessions scheduled for March 18 and 19. For more information and to register, visit **www.entnet.org/content/coding-workshops**.
- **Quality education:** Attend sessions that will enhance your knowledge, competence, and practice as an otolaryngologist-head and neck surgeon. ■

Registration information

There is no cost to attend the AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting for Academy Members who are otolaryngology practitioners, but registration is required. Register today and look for more on scheduling and housing at **www.entnet.org/leadershipforum**.

Deadline

Tuesday, March 8, 2016

Resident leadership grants

AAO-HNS residents and fellows-in-training in good standing are eligible to apply for a $350 grant to help defray the costs of attending the AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting. For more information and to apply, visit **www.entnet.org/leadershipforum**.

Invitation-only meetings

Invitation-only meetings occurring during the AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting include:* Second Annual Specialty Unity Summit, BOD Executive Committee, BOG Executive Committee, Comprehensive Curriculum Task Force, Development Committee, Intraoperative Nerve Monitoring Task Force, Instruction Course Advisory Committee, Program Advisory Committee, Specialty Society Advisory Council, Science and Education Committee, Section for Residents and Fellows-in-Training Governing Council, WIO Governing Council, and the Young Physicians Governing Council.

**Subject to change*

BOARD OF GOVERNORS

Centered leadership

■ **Stacey L. Ishman, MD, MPH**, chair-elect, Board of Governors

We all went into medicine to make a difference in the world. We hope that you will join us at the AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting to do just that. This year's meeting will be full of exciting topics, which are focused on diversity, advocacy, and leadership.

This year's meeting is based on the following premise. Whether you are focused on one patient at a time or changes that can affect entire populations, each of us has trained to be a leader. There are many leadership models, but one that resonates with me is the concept of centered leadership, which is published by McKinsey & Company. They describe five dimensions:

- Meaning
- Managing energy
- Positive framing
- Connecting
- Engaging

Meaning

True leadership requires you to explore and understand your strengths instead of focusing on your weaknesses. Once you understand your areas of greatest strength, you will find that using and maximizing them will allow you to work more effectively toward your goals.

Managing energy

In addition, understanding what gives you energy is important so you can make sure these experiences are integrated into your day. This may mean you give yourself some time to regenerate quietly after a busy clinic, or you meet up with colleagues to have a rousing conversation after work. Either way, it is important to find the situations that get you excited and energize you.

Positive framing

At the same time, it is important to regroup when things are not going your way. All of us experience frustration, but the ability to look at these obstacles as opportunities to grow can help you expand your horizons and push forward in the face of adversity.

Connecting

It is also important to find opportunities to meet people who can help you attain your goals and expand your skillset. Build meaningful relationships that help you feel better about yourself. It may be as simple as an email, phone call, or *Bulletin* article, but make sure your words and actions match your goals.

Engaging

While connecting with others is important, and collaboration is critical, it is just as important to find your own voice and develop a sense of self-reliance. This will improve your confidence and enable you to be receptive to learning opportunities.

AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting, March 18-21

We will be discussing issues such as these, along with advocacy and society engagement, at the AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting, in Alexandria, VA, March 18-21. This is a fantastic opportunity to connect with your colleagues while honing your leadership skills. At the same time, there are ample opportunities to network with the leadership of our Academy and ask questions directly to the 2016 candidates for AAO-HNS/F president at the BOG-sponsored Candidates Forum. The meeting will also feature the BOG General Assembly, advocacy training, renowned luncheon speakers, leadership development opportunities, a mENTorConnect Reception, the noteworthy ENT PAC Reception (for Leadership Club donors), CME credits, and more.

I hope to see you there. ■

Mentorship: reflections

The Young Physician Section (YPS) of the American Academy of Otolaryngology—Head and Neck Surgery represents the needs of otolaryngologists under 40 years old or in their first eight years in practice. Two Academy Members with these qualifications reflect on the mentorship relationship from both sides of the coin.

Young Physician Section Member and mentee: **Jonathan C. Kopelovich, MD**

For young otolaryngologists, guidance comes in many guises. Formal mentorship is an intrinsically valuable component of most residency and fellowship programs. Effective interactions usually begin with set goals, duration, and frequency of meetings, and ideally endure beyond the end of training. Over time mentors may evolve into "coaches" or sponsors. Atul Gawande, MD, PhD, has thoughtfully written about requesting the scrutiny of former mentors or retired surgeons with goodwill to fine-tune and improve the performance of young surgeons. The AAO-HNS has proposed fostering "sponsors" for young physicians based on mutual interests and career paths to assist recent graduates in realizing their aspirations and to integrating with the larger otolaryngology community.

Informal mentorship, in contrast, is not mandatory or scripted. The mentor and mentee find each other through shared values or experience and the relationship is not prescribed. I found my informal mentor during a year of cochlear implant research. **Marc D. Eisen, MD**, then a graduating resident on the verge of an otology fellowship, shared my enthusiasm for hearing research and curiosity about medical history. I respected Marc for his intellect and judgment both inside and outside of the hospital, and subsequently consulted with him on letters, interviews, rank lists, research, and more. We maintain contact and I appreciate his willingness to help me sort through and then guide my (sometimes crazy) ideas. He provides invaluable advice, not only because I trust him, but because he provides an outside perspective distinct from the advice of my formal mentors. Our shared experiences make me more comfortable discussing the personal factors and stressors surrounding many of these same decisions.

There is much written about the ideal mentor—as friend, font of information, intellectual role model, and career guide. I think there are both professional and psychosocial benefits for young otolaryngologists across the mentor spectrum. I will continue to rely on mentors from residency and fellowship for advice regarding difficult patients, to help me vet new techniques and practices, and for collaboration on innovations in the field. Once my practice is up and running I would love to have a "coach"—someone to give me concrete and incremental steps to enhance my efficiency and improve my outcomes. And I will continue to rely on Marc to help formulate the broad strokes and navigate big transitions with grace. ■

"He provides invaluable advice, not only because I trust him, but because he provides an outside perspective distinct from the advice of my formal mentors. Our shared experiences make me more comfortable discussing the personal factors and stressors surrounding many of these same decisions."

Jonathan C. Kopelovich, MD
Mentee

from both sides

Mentor: **Marc D. Eisen, MD**

➲ READ MORE ONLINE
References available

I have been fortunate to have had outstanding mentors in the realms of science, academia, and patient care—each aspect of my professional development. In retrospect, I actively sought my mentors and cultivated these relationships to what I hope was mutual benefit. As an established clinician, now more likely to take on the role of mentor rather than mentee, I hope to pass on the valuable qualities that my mentors demonstrated to me. What follows are some guidelines to reveal the key ingredients of a successful mentor-mentee relationship.

Choose a mentor who has a vested interest in your success.
The source of this vested interest doesn't need to be readily apparent. Being from the same institution, having shared a similar path or background, or working together in a formal teacher-student relationship are the most likely ingredients generating this investment. This relationship may be implied rather than formally stated.

Find a mentor in a non-threatening position.
The world of medicine can be competitive. My mentors were about half a generation ahead of me in career status and did not have jobs or positions I could pursue. A status too close (such as co-residents or resident-fellow) can be threatening to the mentor, while a status too far removed (resident and attending at the end of a career, for example) can lack helpful shared experiences. Jonathan has been the ideal interval behind me in training—a medical student when I was a resident, an intern when I was a fellow, and a fellow while I am a young (ish!) attending.

2015 AAO-HNSF Annual Meeting attendees.

Don't burden your mentor with added time commitments.
In medicine, daily lives leave little time for non-essential activities. Clinical work, academic productivity, meetings, family, hobbies, and an occasional good night's sleep consume most of our time. It is unnecessary for mentors and mentees to have hours of meetings or burdensome obligations for valuable results. Email correspondence or occasional phone calls are typically all that is required to foster the relationship.

It is okay to choose a mentor that helps with only one aspect of professional development.
One of my scientific mentors was a fantastic researcher and academician, but lacked experience or knowledge about clinical medicine. Another served as a sounding board for clinical issues but has no knowledge or expertise in scientific or academic issues. Mentors need not be omniscient in all aspects of your professional development.

I would not be where I am today without the guidance of my mentors. They generated confidence in my work and potential, and guided me through important decisions. Their own experiences and paths served as guideposts that I could follow or disregard within the sea of anonymity that training in large otolaryngology programs can appear to be. ➲

> A status too close (such as co-residents or resident-fellow) can be threatening to the mentor, while a status too far removed (resident and attending at the end of a career, for example) can lack helpful shared experiences.
>
> **Marc D. Eisen, MD**
> *Mentor*

Interested in mentorships?

Find out about mENTorConnect at **entconnect.entnet.org/participate/mentorconnect**.

Meaningful Use changes in 2016?

According to Andy Slavitt, acting administrator at the Centers for Medicare & Medicaid Services (CMS), the physician community can expect major changes to Meaningful Use (MU) in 2016. While speaking at a conference in mid-January, Slavitt said, "The Medicare Access & CHIP Reauthorization Act of 2015, with its emphasis on a new Merit-Based Incentive Payment System and alternative payment models, demands a new streamlined regulatory approach … In 2016, MU as it has existed—with MACRA—will now be effectively over and replaced with something better." Slavitt continued on to say, "We have to get the hearts and minds of physicians back. I think we've lost them."

As many AAO-HNS Members are aware, the Academy's Health Policy and Legislative Advocacy teams have been working to promote greater flexibility, interoperability, and less stringent MU reporting requirements for physicians. Therefore, Slavitt's announcement was welcomed by the Academy, and represents a long-sought recognition by policymakers that the MU program has not functioned as it was originally intended. As CMS moves forward with implementing a new or revised program under MACRA, the AAO-HNS, and our partners in the physician community, will remain diligent in our efforts to ensure the pitfalls of the original program are not replicated in the future.

The AAO-HNS recognizes the importance of this potential change for our Members. As such, information regarding any new or revised MU-related program will be provided as quickly as possible—via the *Bulletin*, ENTConnect, and/or other Academy communications. ■

New Expert Series, courses join AcademyU® lineup

The Foundation has just published a new and exciting education resource. It is called the Annual Meeting Expert Series. This series of online courses can be accessed through **www.academyu.org**.

The Expert Series includes 19 complete video recordings of select Annual Meeting sessions. **Sonya Malekzadeh, MD**, and **Richard V. Smith, MD**, coordinators for Education, chose these sessions based on critical and timely topics of great relevance to AAO-HNS Members that were presented by key leaders in the field.

The Expert Series includes 19 complete video recordings.

In addition to the video recordings, seven of the sessions were selected for a special Expert Interview following their talks conducted by Foundation Education leaders:

Evidence-based Approach to Treating Oral Cavity Cancer, 2015 Update
Neil D. Gross, MD, and **Dennis H. Kraus, MD**

Discussing HPV-Head and Neck Cancer: Diagnosis and Beyond
Carole Fakhry, MD, MPH, and **Christine G. Gourin, MD**

Controversies in Parotid Surgery: Is There Evidence?
Richard V. Smith, MD

Persistent OSA: An Evidence-based Approach to Treatment
Norman R. Friedman, MD

Current Treatment of Lymphatic Malformations
Charles A. Hughes, MD, MBA, MPH

AAO-HNSF CPG Adult Sinusitis Update
Richard M. Rosenfeld, MD, MPH

State of the Art: Drug-induced Sedated Endoscopy for OSA
B. Tucker Woodson, MD

Many of the sessions incorporated audience response into the presentations. This feature has been added to the online courses, making them just as interactive for the viewers as the live sessions. Both the session recordings and the interviews offer CME credit upon successful completion of a post-test.

Also being published this month are seven newly video-recorded Clinical Fundamentals talks and seven Specialty-specific Review Courses—both great resources for certification and recertification. The Clinical Fundamentals online lectures are still a requirement for recertification and, unlike in the past, these are full video recordings. They are also now available free to Members. The Review Courses have been held for the past few years at the Annual Meeting & OTO EXPO℠ but this is the first time they have been video recorded and made available in AcademyU®.

Check out these new resources and the more the 200 other Foundation education activities at **www.academyu.org**. ■

Receive one course free by using this coupon code: **AmES2016**

Leaders of the PAC

The ENT PAC Board of Advisors thanks our Leadership Club Investors for their generous support to ensure the specialty has a powerful voice on Capitol Hill. With your support, otolaryngology-head and neck surgery is ensured a seat at the table on issues impacting our profession, our practices, and our patients. Read the full 2015 list of contributors online, including categories for the General Member, Practice Investors, and AAO-HNS staff. Program year: January 1, 2015, through December 31, 2015.

ENT PAC

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Smile restoration in Santa Marta, Colombia

■ **Sameep Kadakia, MD**, Humanitarian Travel Grant Awardee

Volunteers from Healing the Children Northeast last year operated on 67 children in Santa Marta, Colombia, seeing a variety of cases including cleft lip, cleft palate, congenital ptosis, velopharyngeal insufficiency, burn injury, and Mobius syndrome. Left to right are Stefan Shauib, MD, Joseph Rousso, MD, Andrew Jacono, MD, Melanie Malone, MD, and Sameep Kadakia, MD.

➲ READ MORE ONLINE

AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

Dear Arches Natural Products, Inc.,

The American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) is pleased to respond to your open letter.

Construction of a Clinical Practice Guideline requires a repeatable, standardized methodology that reviews published literature relating to the subject matter that is written in the English language. A diverse group of participants including physicians from many specialties then comes together to create a guideline. The recommendations are based off the above-mentioned literature and are based on a preponderance of the literature. The AAO-HNSF guideline is not intended as a sole source of guidance in managing patients with tinnitus. Rather, it is designed to assist clinicians and patients by providing an evidence-based framework for decision-making strategies. Failure to include a specific treatment regimen does not mean that said regimen cannot be effective, but rather that the English literature does not offer sufficient proof to demonstrate said effectiveness. Final recommendations also reflect the panel's assessment of the risk to benefit ratio to patients using the products.

The AAO-HNSF Clinical Practice Guideline: Tinnitus, published in 2014, does include a recommendation that clinicians should not recommend *Ginkgo biloba*, melatonin, zinc, or other dietary supplements for treating patients with persistent, bothersome tinnitus.

The AAO-HNSF systematic review of the literature revealed Randomized Control Trials and systematic reviews with extreme heterogeneity and there were significant concerns related to the methodology and subject selection. The guideline development group (GDG) had a low confidence level in benefits due to methodological concerns and study quality and ability to generalize results to patients with persistent, primary tinnitus. In addition, as noted by Arches, the GDG had concerns regarding the actual content and dosage of proposed active agents in the preparations included in many studies. The GDG was also concerned about potential drug interactions and adverse events. The Holstein review mentioned in your letter is available only in German, which precludes its usage in the CPG discussion. Should additional literature, available in English, become available it will certainly be considered in the ongoing maintenance process applicable to all of our guidelines.

Respectfully,

James C. Denneny III, MD
Executive Vice President and CEO
The American Academy of Otolaryngology—Head and Neck Surgery Foundation

UPDATED CLINICAL PRACTICE GUIDELINE

Otitis Media with Effusion

Adapted from the February 2016 Supplement to ***Otolaryngology–Head and Neck Surgery***. Read the guideline at **otojournal.org**.

New evidence, systematic reviews, randomized control trials, and an evolved methodology that includes consumers necessitated an update to "Clinical Practice Guideline: Otitis Media with Effusion," released this month as a supplement to *Otolaryngology–Head and Neck Surgery*. The update, already endorsed by the American Academy of Family Physicians (AAFP), replaces the 2004 guideline co-developed by the AAO-HNSF, the AAFP, and the American Academy of Pediatrics (AAP).

Richard M. Rosenfeld, MD, MPH, chaired both the 2004 guideline and the 2016 update.

"You really could call OME an occupational hazard of early childhood," said Dr. Rosenfeld. "Given its prevalence—most kids will experience it by the time they are school age—we emphasize materials in this update that will help doctors better communicate with parents and caregivers. There are new teaching aids, frequently asked questions, and grids to aid in shared decision-making."

Other differences between the 2004 guideline and the 2016 update include:

- additional information on pneumatic otoscopy and tympanometry to improve diagnostic certainty;
- expanded information on speech and language assessment for children with otitis media with effusion (OME);
- new recommendations for managing OME in children who fail a newborn hearing screen and for evaluating at-risk children;
- a new recommendation against using topical intranasal steroids;
- a new recommendation against adenoidectomy for a primary indication of OME in children under 4 years of age;
- a new recommendation for assessing OME outcomes.

"Physicians will notice that each state-

ment in the guideline explicitly links with a quality improvement opportunity, and we've included an algorithm flow chart that links all the statements together in a cohesive and understandable way," Dr. Rosenfeld said.

The full guideline, as well as other resources, is available at **www.entnet.org/OMECPG** as well as in *Otolaryngology--Head and Neck Surgery* as published at **otojournal.org**.

Guideline recommendations

Pneumatic otoscopy (a)

The clinician **should** document the presence of middle ear effusion with pneumatic otoscopy when diagnosing OME in a child.

Pneumatic otoscopy (b)

The clinician **should** perform pneumatic otoscopy to assess for OME in a child with otalgia, hearing loss, or both.

Tympanometry

Clinicians **should** obtain tympanometry in children with suspected OME for whom the diagnosis is uncertain after performing (or attempting) pneumatic otoscopy.

Failed newborn hearing screen

Clinicians **should** document in the medical record counseling of parents of infants with OME who fail a newborn hearing screen regarding the importance of follow-up to ensure that hearing is normal when OME resolves and to exclude an underlying sensorineural hearing loss (SNHL).

Identifying at-risk children

Clinicians **should** determine if a child with OME is at increased risk for speech, language, or learning problems from middle ear effusion because of baseline sensory, physical, cognitive, or behavioral factors.

Evaluating at-risk children

Clinicians **should** evaluate at-risk children for OME at the time of diagnosis of an at-risk condition and at 12 to 18 months of age (if diagnosed as being at-risk prior to this time).

Screening healthy children

Clinicians **should not** routinely screen children for OME who are not at-risk and do not have symptoms that may be attributable to OME, such as hearing difficulties, balance (vestibular) problems, poor school performance, behavioral problems, or ear discomfort.

Patient education

Clinicians **should** educate families of children with OME regarding the natural history of OME, need for follow-up, and the possible sequelae.

Watchful waiting

Clinicians **should** manage the child with OME who is not at-risk with watchful waiting for three months from the date of effusion onset (if known) or three months from the date of diagnosis (if onset is unknown).

Steroids

Clinicians **should recommend against** using intranasal steroids or systemic steroids for treating OME.

Antibiotics

Clinicians **should recommend against** using systemic antibiotics for treating OME.

Antihistamines or decongestants

Clinicians **should recommend against** using antihistamines, decongestants, or both for treating OME.

Hearing test

Clinicians **should** obtain an age-appropriate hearing test if OME persists for three months or longer OR for OME of any duration in an at-risk child.

Speech and language

Clinicians **should** counsel families of children with bilateral OME and documented hearing loss about the potential impact on speech and language development.

Surveillance of chronic OME

Clinicians **should** reevaluate, at three- to six-month intervals, children with chronic OME until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.

Surgery for children less than 4 years old

Clinicians **should** recommend tympanostomy tubes when surgery is performed for OME in a child less than 4 years old; adenoidectomy should not be performed unless a distinct indication (e.g., nasal obstruction, chronic adenoiditis) exists other than OME.

Surgery for children age 4 years old or older

Clinicians **should** recommend tympanostomy tubes, adenoidectomy, or both when surgery is performed for OME in a child 4 years old or older.

Outcome assessment

When managing a child with OME clinicians **should** document in the medical record resolution of OME, improved hearing, or improved quality of life (QOL).

Guideline authors

Richard M. Rosenfeld, MD, MPH; Jennifer J. Shin, MD, SM; Seth R. Schwartz, MD, MPH; Robyn Coggins, MFA; Lisa Gagnon, MSN, CPNP; Jesse M. Hackell, MD; David Hoelting, MD; Lisa L. Hunter, PhD, FAAA; Ann W. Kummer, PhD, CCC-SLP; Spencer C. Payne, MD; Dennis S. Poe, MD, PhD; Maria Veling, MD; Peter M. Vila, MD, MSPH; Sandra A. Walsh, and Maureen D. Corrigan. ■

PATIENT INFORMATION ON

Treating and Managing Ear Fluid

QUESTION	ANSWER
What is ear fluid?	Ear fluid, also called otitis media with effusion (OME), is a build-up of mucus or liquid behind the ear drum without symptoms of infection.
Is it possible that the ear fluid will just go away on its own?	Fluid often goes away on its own, so your doctor will often recommend watchful waiting for the first 3 months. Be sure to follow-up with your doctor to make sure the fluid goes away completely .
Does it matter how long the fluid has been there?	The fluid is most likely to go away quickly if it has been there less than 3 months or has a known start time, such as after a cold or ear infection. Fluid is much more likely to persist when it has been there for at least 3 months or when it is found during a regular check-up visit and the start date is unknown.
How might the ear fluid affect my child?	The most common symptoms of ear fluid are mild discomfort, fullness in the ear, and mild hearing problems. Some children also have disturbed sleep, emotional distress, delayed speech, irritability, clumsiness, balance problems, or trouble learning in school.
What can I do at home to help the fluid go away?	Keep your child away from second-hand smoke, especially in closed spaces like the car or in the house. If your child is more than 12 months old and still uses a pacifier, stopping the pacifier in the daytime may help the fluid go away.
Will medications or other therapies help the fluid go away?	Medical treatment does not work well, so you should not give your child antibiotics, antihistamines, decongestants, steroids (by mouth or in the nose), or drugs to reduce acid reflux. No benefits have ever been shown for chiropractic, special diets, herbal remedies, complementary medicine, or alternative (natural) therapies.
Do I still need to follow-up with my doctor, even if my child seems fine?	Yes, because the fluid may still be there and could later cause problems. Fluid that lasts a long time can damage the ear and require surgery. Also, young children often do not express themselves well, even when struggling with hearing problems or other issues related to the fluid. The best way to prevent problems is to see the doctor every 3 to 6 months until the fluid goes away.

Continued on reverse

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

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ABOUT THE AAO-HNS/F

The American Academy of Otolaryngology–Head and Neck Surgery (www.entnet.org), one of the oldest medical associations in the nation, represents about 12,000 physicians and allied health professionals who specialize in the diagnosis and treatment of disorders of the ears, nose, throat and related structures of the head and neck. The Academy serves its members by facilitating the advancement of the science and art of medicine related to otolaryngology and by representing the specialty in governmental and socioeconomic issues. The AAO-HNS Foundation works to advance the art, science, and ethical practice of otolaryngology–head and neck surgery through education, researach, and lifelong learning. The organization's vision: "Empowering otolaryngology–head and neck surgeons to deliver the best patient care."

PATIENT INFORMATION ON

Treating and Managing Ear Fluid

QUESTION	ANSWER
Does the fluid cause hearing loss?	The fluid can make it harder for your child to hear, especially in a group setting or with background noise, but the effect is usually small and goes away when the fluid clears up.
How can I help my child hear better?	Stand or sit close to your child when you speak and be sure to let them see your face. Speak very clearly, and if your child does not understand something, repeat it. Hearing difficulties can be frustrating for your child, so be patient and understanding. See Table 11 in the full guideline for specific strategies.
Will the fluid turn into an ear infection?	The fluid cannot directly turn into an ear infection, but during a cold it increases your child's risk of getting an ear infection because the fluid makes it easier for germs to grow and spread.
Can my child travel by airplane if ear fluid is present?	If the ear is completely full of fluid there is usually no problem, but when the fluid is partial or mixed with air it can hurt when the plane is coming down. Your doctor can measure the amount of fluid with a tympanogram, which gives a flat reading when the ear is full. It may help to keep your child awake when the plane is landing and encourage him or her to swallow to even out the pressure.

SOURCE: Rosenfeld RM, Shin JJ, Schwartz SR, et al. Clinical practice guideline (update): otitis media with effusion. *Otolaryngol Head Neck Surg.* In press.

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We care for kids

General otolaryngologists can successfully treat the majority of ENT-related pediatric diseases

By **Sujana S. Chandrasekhar, MD**, AAO-HNS/F President with **James C. Denneny III, MD**, AAO-HNS/F EVP/CEO

As we commemorate Kids ENT Health Month, it is important to remember the historic contributions the field of otolaryngology has made in the care of sick children. Historically, general otolaryngologists have successfully treated the full spectrum of ENT-related pediatric diseases for generations, and organ-specialized ENTs led advances in many disease-specific areas for children of all ages. The field of "pediatric otolaryngology" really took off in the 1980s, primarily around diseases of the airway. This led to a proliferation of fellowships in pediatric otolaryngology of widely varying training opportunities and accreditation. In order to standardize pediatric fellowship training and recognize additional training, the American Board of Otolaryngology (ABOto) has decided to proceed with subcertification in "complex pediatric otolaryngology." At the current time a final decision has not been made as to who will be able to sit for the subcertification examination. It is important to recognize that "pediatric otolaryngology" is listed as a core competency on the primary certificate issued by the ABOto.

The combination of the pending subcertification in complex pediatric otolaryngology, aggressive marketing by some pediatric otolaryngologists and children's hospital systems, and the American Academy of Pediatrics (AAP) referral recommendations has resulted in confusion on the part of both the public and referring physicians as to what is appropriate for the general otolaryngologist as well as the specialty-trained otolaryngologist to treat. The AAO-HNS has reached out directly to AAP to clarify the issue. While the ABOto definition of "complex" is not precise, it is clear that the majority of pediatric patients do not fall into the "complex" category. To claim that otolaryngologists who have not had a pediatric fellowship are not qualified to treat the vast majority of pediatric patients flies in the face of years of training and successful practice and does a disservice to many patients who are routed long distances or otherwise inconvenienced instead of receiving excellent ongoing care locally. Those patients who do have "complex" problems can receive outstanding care from fellowship-trained otolaryngologists across the country.

Otolaryngologists will continue to define best treatment and improve quality of care to our pediatric patients. This effort will be greatly enhanced as we roll out our clinical data registry, Regent[SM]. ■

Kids ENT Health Month

Quick tips to share with patients and caregivers

Kids ENT Health Month is important as it helps raise awareness about common problems that children encounter in the ear, nose and throat," explained **David R. White, MD**, chair of the AAO-HNS Pediatric Otolaryngology Committee.

Conditions that can bring a child to an otolaryngologist include ear problems, hearing and speech problems, nasal congestion, nose bleeding, sinus issues, sleep apnea and snoring, aliments of the throat, and difficulties swallowing.

"There are so many important structures within the head and neck that affect a child's development—the ability to hear, to speak, to smell, to breathe, to swallow, to taste—all of these are hugely important for leading a normal life," said **Dale A. Tylor, MD**, chair of the AAO-HNS Media and Public Relations Committee. "If a child has a problem with these actions, there's usually a treatment but it takes getting checked out to find out."

"One of the reasons children are most likely to see an ENT is for issues related to the ears, particularly when problems are recurrent or chronic," said Dr. White.

"The intent behind Kids ENT Health Month is for education to the public, but I think the observance also helps to remind those of us in the medical community of what the most recent guidelines say," Dr. White said.

This February, Kids ENT Health Month coincides with the release of "Updated Clinical Practice Guideline: Otitis Media with Effusion," published as a supplement to *Otolaryngology–Head and Neck Surgery*.

The updated guideline on OME, or ear fluid, is profiled here in the *Bulletin*

Learn more online

Ear, nose, and throat ailments remain among the primary reasons children visit a physician. Visit **www.entnet.org/KidsENT** and access materials prepared for you to observe Kids ENT Health Month.

Connect with your community and take a lead in raising awareness about pediatric ear, nose, and throat disorders.

on page 14, and was released alongside a patient-friendly plain language summary and tables of frequently asked questions.

Kids ENT Health Month quick tips

1. **Put the cotton swabs down.** The ear has an amazing ability to clean itself out and, in fact, the act of trying to clean the ear out with a cotton swab can sometimes push the wax back down and cause a buildup of wax that can then impair hearing. You shouldn't be putting anything smaller than your elbow in your ear.
2. **Watch out for foreign bodies and nuts.** Small toy parts, button batteries, and small magnetic parts can be life-threatening if ingested. Examples include batteries from hearing aids, watches, and noise-making greeting cards. Also be cautious not to feed children nuts until they develop molars and are able to grind the food down.
3. **Consult an ENT doctor if there are concerns about a child's hearing or speech development.** Speech develops at varying rates so not every child will develop the same, but if development stalls or is not happening, an assessment may find a structural problem in the mouth or a hearing-related issue that can be addressed.
4. **Take snoring seriously.** It's not uncommon for a child to snore while they have nasal congestion, but if they're snoring every night or have pauses in their breathing (called apneas) that can have significant impact on their health and quality of life, causing headaches and affecting attention spans and academic performance. ■

> "There are so many important structures within the head and neck that affect a child's development—the ability to hear, to speak, to smell, to breathe, to swallow, to taste—all of these are hugely important for leading a normal life."
>
> **Dale A. Tylor, MD**
> *Chair of the AAO-HNS Media and Public Relations Committee*

2016 payment updates

Facts you need to know about healthcare system changes

The Academy works closely with the Centers for Medicare & Medicaid Services (CMS) to maintain our visibility and credibility with the Agency by submitting comments every year on proposed and final federal regulatory policies that impact otolaryngology-head and neck surgeons. The Academy's role is to advocate on behalf of Members and provide resources to educate Members on current and future national payment policies. As part of this effort, we have worked to summarize the following regulations, drafted comments to CMS, and developed fact sheets on specific programs to assist Members as you navigate the changing healthcare system.

Merit-based Incentive Payment System and eligible Alternative Payment Models

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the SGR and created two new payment update tracks effective January 1, 2019: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). The MIPS program will take components of currently existing CMS quality programs to determine physician payment. Providers participating in qualified APMs will receive bonus payments in addition to regular updates. To learn more about MACRA and how the Academy is advocating for you as Medicare transitions to accommodate the regulatory changes created by the MACRA legislation, visit this page: **www.entnet.org/content/regulatory-advocacy**.

2016 Medicare Physician Fee Schedule (MPFS)

This program takes into account guidance from the AMA and specialty societies to schedule the broad payment rate across the entire Medicare payment system as well as payment rates for specific procedures. The current CMS quality program rewards and penalties are also established through this rule. The comments address several specific payment policy issues affecting otolaryngology including: practice expense changes; Global Surgical Package valuation; Physician Quality Reporting System and Qualified Clinical Data Registry requirements; Physician Compare; and Value Based Payment Modifier program. To read past comment letters visit this page: **www.entnet.org/content/comment-letters**. To learn more about how each fee schedule rule has impacted otolaryngologist-head and neck surgeons, please visit this page: **www.entnet.org/SummariesofRegulations**.

Electronic Health Records (EHR) and Meaningful Use (MU)

This rule establishes the rewards and penalties within the Medicare systems for EHR usage and reporting. In October 2015, CMS released the MU Modifications on Stage 2 and Stage 3 final rule. CMS finalized that Stage 3 Meaningful Use will be optional in 2017 and required for all participants beginning in 2018. It is very likely that the overall EHR MU requirements will be rolled into MIPS and APM requirements.

On December 7, 2015, the Academy submitted comments on the CMS final rule. Comments focused on the need for increased flexibility, interoperability, continuation of 90-day reporting periods, and measure thresholds and requirements. To see the Academy's comments on EHR MU and read about the Academy's efforts to modify or delay MU requirements, visit: **www.entnet.org/content/electronic-health-records-ehr-and-meaningful-use**.

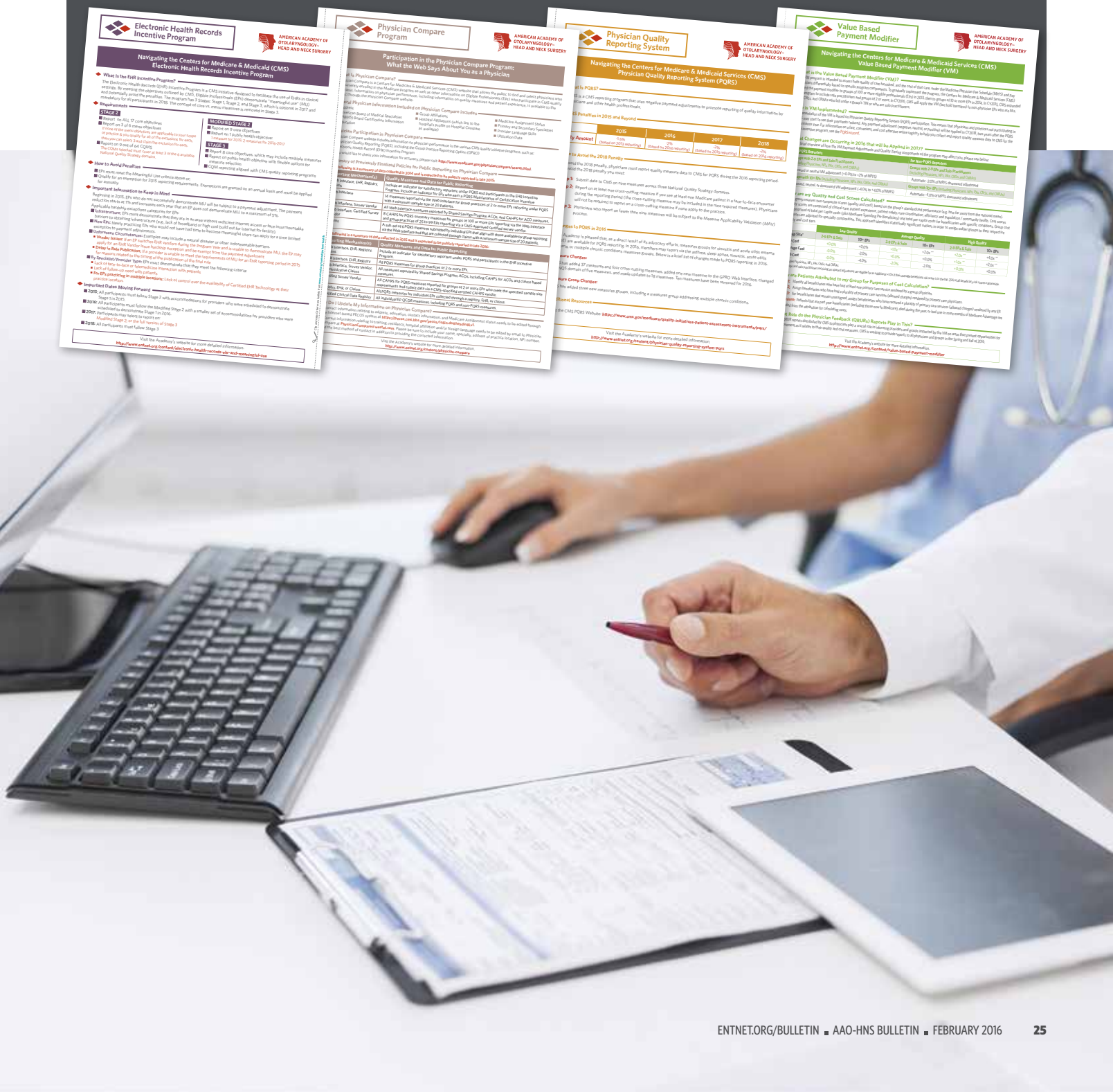
2016 CMS Quality Reporting Initiatives Fact Sheets

This year, physicians will be subject to new requirements for many CMS quality reporting initiatives. To help Members understand the reporting requirements, the Academy's Health Policy team has once again created one-page fact sheets for each of the CMS initiatives. The fact sheets provide Members with key information, such as reporting deadlines, reporting requirements, changes for 2016, and much more. Members are encouraged to use the factsheets as quick references. For detailed information on all of these programs, visit the Academy's CMS Quality Initiatives webpage at **www.entnet.org/content/cms-quality**. ■

2016 CMS Quality Reporting Fact Sheets

The Academy has updated the following fact sheets for the Physician Quality Reporting System (PQRS), Value Based Payment Modifier (VBM), Physician Compare, and Electronic Health Records (EHR) CMS Quality Reporting programs.

For more information on potential changes to the Electronic Health Records Meaningful Use program, please see page 10 for an update. Please look to the News and HP Update for more details on how these possible changes could affect you. ■



Electronic Health Records Incentive Program

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Navigating the Centers for Medicare & Medicaid (CMS) Electronic Health Records Incentive Program

What Is the EHR Incentive Program?

The Electronic Health Records (EHR) Incentive Program is a CMS initiative designed to facilitate the use of EHRs in clinical settings. By meeting the objectives outlined by CMS, Eligible Professionals (EPs) demonstrate "meaningful use" (MU) and potentially avoid the penalties. The program has 3 Stages: Stage 1, Stage 2, and Stage 3, which is optional in 2017 and mandatory for all participants in 2018. The concept of core vs. menu measures is removed in Stage 3.

Requirements

STAGE 2

- Report on ALL 17 core objectives
- Report on 3 of 6 menu objectives
  If none of the menu objectives are applicable to your scope of practice & you qualify for all of the exclusions for each, then you can select 3 and claim the exclusion for each.
- Report on 9 out of 64 CQMS
  The CQMs selected must cover at least 3 of the 6 available National Quality Strategy domains.

MODIFIED STAGE 2

- Report on 9 core objectives
- Report on 1 public health objective:
  1 measure for 2015; 2 measures for 2016-2017

STAGE 3

- Report 8 core objectives, which may include multiple measures
- Report on public health objective with flexible options for measure selection
- CQM reporting aligned with CMS quality reporting programs

How to Avoid Penalties

- EPs must meet the Meaningful Use criteria above or;
- Qualify for an exemption for 2015 reporting requirements. Exemptions are granted on an annual basis and must be applied for annually.

Important Information to Keep in Mind

Beginning in 2015, EPs who do not successfully demonstrate MU will be subject to a payment adjustment. The payment reduction starts at 1% and increases each year that an EP does not demonstrate MU, to a maximum of 5%.

Applicable hardship exceptions categories for EPs:

- **Infrastructure:** EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband or high cost build out for internet for facility).
- **New EPs:** Newly practicing EPs who would not have had time to become meaningful users can apply for a time limited exception to payment adjustments.
- **Unforeseen Circumstances:** Examples may include a natural disaster or other unforeseeable barriers.
  - **Vendor Issues:** If an EP switches EHR vendors during the Program Year and is unable to demonstrate MU, the EP may apply for an EHR Vendor Issue hardship exception and be exempt from the payment adjustment
  - **Delay in Rule Publication:** If a provider is unable to meet the requirements of MU for an EHR reporting period in 2015 for reasons related to the timing of the publication of the final rule
- **By Specialist/Provider Type:** EPs must demonstrate that they meet the following criteria:
  - Lack of face-to-face or telemedicine interaction with patients
  - Lack of follow-up need with patients
  - **For EPs practicing in multiple locations:** Lack of control over the availability of Certified EHR Technology at their practice location.

Important Dates Moving Forward

- **2015:** All participants must follow Stage 2 with accommodations for providers who were scheduled to demonstrate Stage 1 in 2015.
- **2016:** All participants must follow the Modified Stage 2 with a smaller set of accommodations for providers who were scheduled to demonstrate Stage 1 in 2016.
- **2017:** Participants may select to report on:
  Modified Stage 2; or the full version of Stage 3
- **2018:** All participants must follow Stage 3

Visit the Academy's website for more detailed information.
http://www.entnet.org/content/electronic-health-records-ehr-and-meaningful-use

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Physician Compare Program

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Participation in the Physician Compare Program: What the Web Says About You as a Physician

What Is Physician Compare?

Physician Compare is a Centers for Medicare & Medicaid Services (CMS) website that allows the public to find and select physicians who are currently enrolled in the Medicare program as well as other information on Eligible Professionals (EPs) who participate in CMS quality programs. Information on physician performance, including information on quality measures and patient experience, is available to the public through the Physician Compare website.

General Physician Information Included on Physician Compare includes

- Address
- American Board of Medical Specialties (ABMS) Board Certification Information
- Education
- Group Affiliations
- Hospital Affiliations (which link to the hospital's profile on Hospital Compare as available)
- Medicare Assignment Status
- Primary and Secondary Specialties
- Provider Language Skills
- Utilization Data

Physician Participation in Physician Compare

Physician Compare website includes information on physician performance in the various CMS quality initiative programs, such as:

- Physician Quality Reporting (PQRS), including the Group Practice Reporting Option (GPRO)
- Electronic Health Record (EHR) Incentive Program

If you would like to check your information for accuracy, please visit: **http://www.medicare.gov/physiciancompare/search.html**.

Summary of Previously Finalized Policies for Public Reporting on Physician Compare

The following is a summary of data collected in 2014 and is expected to be publicly reported in late 2015:

Reporting Mechanism(s)	Quality Measures and Data for Public Reporting
Web Interface, EHR, Registry, Claims	Include an indicator for satisfactory reporters under PQRS and participants in the EHR Incentive Program. Include an indicator for EPs who earn a PQRS Maintenance of Certification Incentive
Web Interface	14 measures reported via the Web Interface for group practices of 2 or more EPs reporting under PQRS with a minimum sample size of 20 patients.
Web Interface, Survey Vendor	All Web Interface measures reported by Shared Savings Program ACOs, and CAHPS for ACO measures.
Web Interface, Certified Survey Vendor	8 CAHPS for PQRS summary measures for groups of 100 or more EPs reporting via the Web Interface and group practices of 25 to 99 EPs reporting via a CMS-approved certified survey vendor.
Claims	A sub-set of 6 PQRS measures submitted by individual EPs that align with those available for group reporting via the Web Interface and that are collected through claims with a minimum sample size of 20 patients.

The following is a summary of data collected in 2015 and is expected to be publicly reported in late 2016:

Reporting Mechanism(s)	Quality Measures and Data for Public Reporting
Web Interface, EHR, Registry, Claims	Include an indicator for satisfactory reporters under PQRS and participants in the EHR Incentive Program.
Web Interface, EHR, Registry	All PQRS measures for group practices of 2 or more EPs.
Web Interface, Survey Vendor, Administrative Claims	All measures reported by Shared Savings Program ACOs, including CAHPS for ACOs and claims based measures.
Certified Survey Vendor	All CAHPS for PQRS measures reported for groups of 2 or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor.
Registry, EHR, or Claims	All PQRS measures for individual EPs collected through a registry, EHR, or claims.
Qualified Clinical Data Registry	All individual EP QCDR measures, including PQRS and non-PQRS measures.

How Do I Update My Information on Physician Compare?

- Incorrect information relating to address, education, contact information, and Medicare Assignment status needs to be edited through the Internet-based PECOS system at **https://pecos.cms.hhs.gov/pecos/login.do#headingLv1**.
- Incorrect information relating to training, residency, hospital affiliation and/or foreign language needs to be edited by email to Physician Compare at **PhysicianCompare@westat.com**. Please be sure to include your name, specialty, address of practice location, NPI number, and the best method of contact in addition to providing the corrected information.

Visit the Academy's website for more detailed information.
http://www.entnet.org/content/physician-compare

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Physician Quality Reporting System

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Navigating the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System (PQRS)

What Is PQRS?

PQRS is a CMS reporting program that uses negative payment adjustments to promote reporting of quality information by physicians and other health professionals.

PQRS Penalties in 2015 and Beyond

	2015	2016	2017	2018
Penalty Amount	-1.5% (based on 2013 reporting)	-2% (based on 2014 reporting)	-2% (based on 2015 reporting)	-2% (based on 2016 reporting)

How to Avoid the 2018 Penalty

To avoid the 2018 penalty, physicians must report quality measure data to CMS for PQRS during the 2016 reporting period. To avoid the 2018 penalty you must:

Step 1: Submit data to CMS on nine measures across three National Quality Strategy domains.

Step 2: Report on at least one cross-cutting measure if you see at least one Medicare patient in a face-to-face encounter during the reporting period (the cross-cutting measure may be included in the nine required measures). Physicians will not be required to report on a cross-cutting measure if none apply to the practice.

Step 3: Physicians who report on fewer than nine measures will be subject to the Measure Applicability Validation (MAV) process.

Changes to PQRS in 2016

The Academy is pleased that, as a direct result of its advocacy efforts, measures groups for sinusitis and acute otitis externa (AOE) are available for PQRS reporting. In 2016, members may report via the asthma, sleep apnea, sinusitis, acute otitis externa, or multiple chronic conditions measures groups. Below is a brief list of changes made to PQRS reporting in 2016.

Measure Changes:

CMS has added 37 measures and four cross-cutting measures, added one new measure to the GPRO Web Interface, changed the NQS domain of five measures, and made updates to 18 measures. Ten measures have been removed for 2016.

Measure Group Changes:

CMS has added three new measures groups, including a measures group addressing multiple chronic conditions.

Additional Resources

Visit the CMS PQRS Website: **https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/**

Visit the Academy's website for more detailed information.
http://www.entnet.org/content/physician-quality-reporting-system-pqrs

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Value Based Payment Modifier

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Navigating the Centers for Medicare & Medicaid Services (CMS) Value Based Payment Modifier (VM)

What is the Value Based Payment Modifier (VM)?

The VM program is intended to assess both quality of care furnished, and the cost of that care, under the Medicare Physician Fee Schedule (MPFS) and pay physicians differentially based on specific program components. To gradually implement the program, the Centers for Medicare & Medicaid Services (CMS) applied the payment modifier to groups of 100 or more eligible professionals (EPs) in 2013, then to groups of 10 or more EPs in 2014. In CY2015, CMS expanded this program to include solo practitioners and groups of 2 or more. In CY2016, CMS will apply the VM (but hold harmless) to non-physician EPs who are PAs, NPs, CNSs, and CRNAs who bill under a group's TIN or who are solo practitioners.

How is VM Implemented?

Implementation of the VM is based on Physician Quality Reporting System (PQRS) participation. This means that physicians and practices not participating in PQRS may start to see their payments reduced. Any payment adjustment (negative, neutral, or positive) will be applied in CY2018, two years after the PQRS performance year. For information on a fast, convenient, and cost effective online registry to help you collect and report quality measure data to CMS for the PQRS incentive program, see the PQRS*wizard*.

What Changes are Occurring in 2016 that will be Applied in 2017?

For a brief overview of how the VM Payment Adjustments and Quality-Tiering components of the program may affect you, please see below:

For PQRS Reporters	For Non-PQRS Reporters
Groups with 2-9 EPs and Solo Practitioners (including Physicians, NPs, PAs, CNSs, and CNRAs)	**Groups with 2-9 EPs and Solo Practitioners** (including Physicians, NPs, PAs, CNSs, and CNRAs)
Upward or neutral VM adjustment (+0.0% to +2% of MPFS)	Automatic -2.0% of MPFS downward adjustment
Groups with 10+ EPs (including Physicians, NPs, PAs, CNSs, and CNRAs)	**Groups with 10+ EPs** (including Physicians, NPs, PAs, CNSs, and CNRAs)
Upward, neutral, or downward VM adjustment (-4.0% to +4.0% of MPFS)	Automatic -4.0% of MPFS downward adjustment

How are my Quality and Cost Scores Calculated?

Each group receives two composite scores (quality and cost), based on the group's standardized performance (e.g. how far away from the national mean). Quality scores are comprised of clinical care, patient experience, patient safety, care coordination, efficiency and population / community health. Cost scores are comprised of total per capita costs (plus Medicare Spending Per Beneficiary) and total per capita costs for beneficiaries with specific conditions. Group cost measures are adjusted for specialty composition. This approach identifies statistically significant outliers in order to assign outlier groups to their respective quality and cost tiers.

	Low Quality		Average Quality		High Quality	
Group Size*	**2-9 EPs & Solo**	**10+ EPs**	**2-9 EPs & Solo**	**10+ EPs**	**2-9 EPs & Solo**	**10+ EPs**
Low Cost	+0.0%	+0.0%	+1.0x **	+2.0x **	+2.0x **	+4.0x **
Average Cost	-0.0%	-2.0%	+0.0%	+0.0%	+1.0x **	+2.0x **
High Cost	-0.0%	-4.0%	-2.0%	-2.0%	+0.0%	+0.0%

* Includes Physicians, NPs, PAs, CNSs, and CNRAs

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

How are Patients Attributed to my Group for Purposes of Cost Calculation?

Step 1: Identify all beneficiaries who have had at least one primary care service rendered by a group physician.

Step 2: Assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.

Step 3: For beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any EP.

Exclusions: Patients that are part year beneficiaries (including those new to Medicare), died during the year, or had one or more months of Medicare Advantage are excluded from the attribution for calculating costs.

What Role do the Physician Feedback (QRURs) Reports Play in This?

The QRUR reports distributed by CMS to physicians play a crucial role in informing providers and groups impacted by the VM on areas that present opportunities for improvement as it relates to their quality and cost measures. CMS is working to provide reports to all physicians and groups in the Spring and Fall of 2016.

Visit the Academy's website for more detailed information.
http://www.entnet.org/content/value-based-payment-modifier

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A Member 'explores' making Voice Day 2016 personal

This year's World Voice Day theme suggests a personal look at what 'resonates' with us, and this search can bring us together for discussion on how we observe the day

By **Chandra M. Ivey, MD**, AAO-HNS Voice Committee

As an election year, 2016 promises to be a year of excitement and change. In the buildup to the election, we are taking time to learn about our presidential candidates in detail. We are learning about positions on taxation, immigration, healthcare reform, and many other topics as candidates debate their views on what they believe to be important to the American public. This investigation of our potential leaders has also offered an opportunity for self-reflection. How do we see ourselves as a country? What is our role in our international community? How do we support ourselves, defend ourselves, and give of ourselves? Our individual and national identities gently sway and shift with the answers to these questions. Do we support and elect our officials based on how they protect us from harm, how they will build our economy, or how they entertain us?

Regardless of political party, background, or economic fortune there are a few generally accepted "truths" that we enter this year with. We are living in one of the most heterogeneous countries in the world. The likelihood that any one view is held by all is low, and the likelihood that something you say may be taken as offensive by at least one other individual in this country is high. This can be a frustrating idea, breeding pessimism and division.

Our challenge is to take these "truths" and use them to support, foster, and create instead of allowing them to divide us.

Exploring our communities, our workplaces, our families, and our inner selves for where we can help and how we can build meaningful connections is becoming even more important. Exploring our voices, what resonates with us, and what we can create with our language can bring us to the table together for discussion. Our words and our views can be used to build or to destroy. We have the power to decide which of these we want to do.

Otolaryngology is a subspecialty designed to support many of the special senses that allow for exploration of our environment. **World Voice**

Day, April 16, emphasizes education about vocal hygiene and support for all to explore their voices. The theme for World Voice Day is explore your voice—imagine where it will take you. I urge us to understand what is truly important to our patients and communities, and to exercise our influence in support of healthy ways to ensure their voices are heard. This support may take many forms. It may be reassuring an individual that his or her cancer is in remission by performing laryngoscopy. It may be participating in a screening program for laryngeal cancer at a local institution. It may be helping to ensure a local teacher can continue her profession by correctly diagnosing a new hemorrhagic polyp and coordinating the assistance she needs. It may be in the form of assisting a candidate in keeping his or her voice powerful through the remainder of the campaign.

Because of our unique skill set, which focuses on direct inspection of the larynx and vocal apparatus, we have a responsibility to raise awareness about prevention and care for common ailments of the voice. Educating primary care physicians and the public about the guidelines for treatment of hoarseness that have been adopted by the American Academy of Otolaryngology—Head and Neck Surgery Foundation and supporting practices such as not offering antibiotics for hoarseness in isolation of other symptoms is a challenge I ask that we all accept.[1] We, in turn, should challenge our patients to support their voices using preventive techniques that will keep them speaking, singing, and debating long into the future.

What could be created by a country of citizens unafraid to explore and engage their voices? What could be accomplished by those unafraid to speak about challenges and change, and unafraid to listen to the blend of views that only such a diverse country as ours is uniquely afforded? When we explore our voices and support others in exploring theirs we create the possibility for cooperation and harmony. Start exploring your voice today! ■

Reference

1. Schwartz SR, Cohen SM, Dailey SH. et al. Clinical Practice Guideline: Hoarseness (Dysphonia). *Otolaryngol Head Neck Surg.* 2009; 141:S1-S31.

www.entnet.org/leadershipforum

AAO-HNS/F LEADERSHIP FORUM & BOG SPRING MEETING

2016 MARCH 18-21 ALEXANDRIA, VA

KEYNOTE SPEAKERS ANNOUNCED!

SATURDAY, MARCH 19

Admiral Christine S. Hunter, MD

Admiral Christine S. Hunter, MD, joined the U.S. Office of Personnel Management as Chief Medical Officer in December 2011, bringing over 30 years of experience in federal health care. As a Navy Rear Admiral and Deputy Director of TRICARE Management Activity from 2009-2011, Hunter coordinated healthcare for 9.6 million military beneficiaries and managed a $22B portfolio. Currently, Hunter serves as Medical Director for the Federal Employees Health Benefit Program, overseeing its healthcare quality initiatives and contributing to the design of new insurance offerings at OPM.

SUNDAY, MARCH 20

Robert M. Tufts

Robert M. Tufts is a former major league baseball player with a degree in Economics from Princeton University, an MBA in Finance from Columbia University School of Business, and over 20 years of experience working on Wall Street. Tufts has also lectured at numerous universities and conducted baseball clinics in the United States and Israel. Mr. Tufts is a cancer survivor and is the co-founder of My Life Is Worth It, a not-for-profit that lobbies for patient and physician access and choice in medical care. Currently, Tufts is an Adjunct Professor at New York University, Manhattanville College, and Yeshiva University.

SUNDAY, MARCH 20

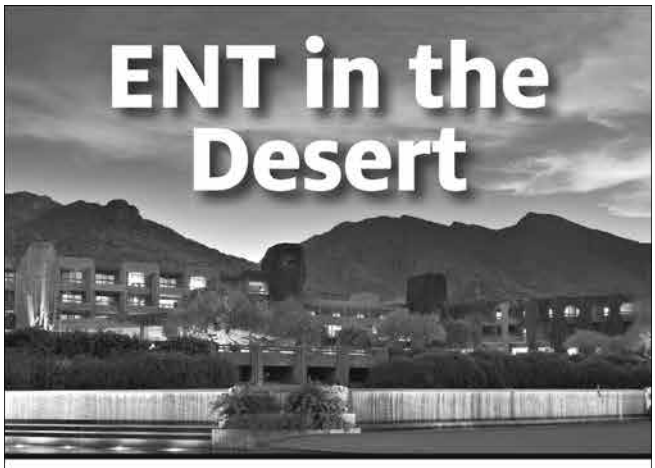
Richard M. Popovic, MBA

Richard M. Popovic, MBA, has served as the Chief Executive Officer for World Wide Medical Solutions, LLC, Institute of Modern Economy, LLC, and Indelta Learning Systems, LLC. Popovic has 20 years of corporate management, strategy, and training experience, as well as 10 years of academic experience as the Dean for Executive Programs and a Professorial Lecturer at the William E. Simon Graduate School of Business at the University of Rochester. Popovic currently serves as Executive Vice President of enhancedcare, Inc., responsible for professional relations and sales.

MONDAY, MARCH 21

Julius W. Hobson, Jr.

Julius W. Hobson, Jr. has more than 40 years of experience in public policy, working both inside and outside of government. As a registered lobbyist and senior policy advisor at Polsinelli PC, Hobson primarily serves healthcare clients, with particular emphasis on physicians, hospitals, home health, and long-term care providers. Hobson is also Adjunct Professor, Graduate School of Political Management, George Washington University, where, since 1994, he has taught Lobbying, Advanced Strategy Lobbying, Fundamentals of Political Management, Electoral and Legislative Processes, and Legislative Writing and Research.



March 10-13, 2016

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Course Directors
Alexander Chiu, MD
Stephen Goldstein, MD, FACS
Abraham Jacob, MD

Distinguished Faculty
Craig A. Buchman, MD, FACS
Frederick J. Menick, MD
Albert L. Merati, MD, FACS
Rodney J. Schlosser, MD
Rahul K. Shah, MD, MBA

New

ENDOSCOPIC EAR COURSE

Saturday, March 12

Director **Abraham Jacob, MD**
Faculty **Alejandro Rivas Campo, MD**
Brandon Isaacson, MD, FACS

FACIAL PLASTIC RECONSTRUCTION COURSE

Saturday, March 12 and Sunday, March 13

Directors **Audrey Erman, MD**
Stephen Goldstein, MD, FACS
Distinguished Faculty **Frederick J. Menick, MD**

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Interested candidates please forward letter of interest and curriculum vitae to Alice via email at ccofps@comcast.net.

University of Maryland Otorhinolaryngology

The Department of Otorhinolaryngology – Head and Neck Surgery is seeking a board certified or board eligible, full-time, academic Pediatric Otolaryngologist to join the faculty. The candidate should be fellowship trained in Pediatric Otolaryngology. Responsibilities include teaching of medical students and residents, patient care and clinical/basic science research.

Faculty rank, tenure status and salary will be commensurate with the level of experience. Qualified applicants should submit their Curriculum Vitae and the names of three references to:

Kevin D. Pereira, M.D., M.S.(ORL), F.A.C.S.
Director of Pediatric Otolaryngology
Department of Otorhinolaryngology – Head & Neck Surgery
University of Maryland
16 South Eutaw St., Suite 500
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Yuma Regional Medical Center (YRMC), a 406 bed top-in-technology facility, is the only acute care hospital of its size within a 170 mile radius and provides almost all modalities of care. We boast a medical staff of over 400 physicians and allied health professionals across the majority of specialties, with more than 94% holding board certification.

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Robert P. Green, MD, FACS
President, ENT and Allergy Associates
rgreen@entandallergy.com

Robert A. Glazer
CEO, ENT and Allergy Associates
914-490-8880 ▪ rglazer@entandallergy.com

Bassett Healthcare Network
Bassett Medical Center

Otolaryngology

Bassett Healthcare Network, a progressive health care network in central New York and major teaching affiliate of Columbia University, is seeking a hospital-employed, full-time BC/BE Otolaryngologist to join as Chief of a busy expanding OHNS practice.

The Division of Otolaryngology-Head & Neck Surgery offers a full range of services including otology, laryngology, facial plastic surgery, sinus surgery, head and neck surgery, research and teaching opportunities. Training in surgical oncology is encouraged but not a requirement.

Bassett Healthcare Network is an integrated health care system that provides care and services to people living in an eight county region covering 5,600 square miles in upstate New York. The organization includes six corporately affiliated hospitals, as well as skilled nursing facilities, community and school-based health centers, and health partners in related fields.

Nestled in the foothills of the Adirondack and Catskill Mountains, Bassett Medical Center is located in Cooperstown, New York, a beautiful resort village on Otsego Lake.

For confidential consideration, please contact:
Debra Ferrari
Bassett Medical Center
One Atwell Road, Cooperstown, NY, 13326
phone: 607-547-6982 • **fax:** 607-547-3651
email: debra.ferrari@bassett.org
or visit our website: www.bassettopportunities.org

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Otologist/Neurotologist

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

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

utmb Health

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

The Department of Otolaryngology at West Virginia University is seeking the following positions:

• **Fellowship-trained Head and Neck Surgeon** to join a well-established head and neck oncology service immediately. Applicants will have expertise with ablative and reconstructive procedures as well as trauma surgery. In addition to providing excellent patient care, the successful candidate will be actively involved in the teaching of medical students and otolaryngology residents. Opportunities are available for those interested in clinical/basic research. The department currently has 14 physician faculty members and fourteen residents in addition to an active NIH-funded research division with three PhD members.

• **A General Otolaryngologist** to expand our general otolaryngology & allergy services. The candidate would be expected to work in our main office as well as in one of our satellite offices. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

• **A board-certified Otolaryngologist Program Director** of the residency training program with 30% protected time, & the rest will be devoted for clinical services at the main campus. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

• A **Pediatric Otolaryngologist** to join a thriving academic practice. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

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

U.S. News & World Report has ranked West Virginia University Hospitals #1 in the state for the last several years. WVUH provides the most advanced level of care available to the citizens of West Virginia and bordering states. Major expansion is underway to Ruby Memorial Hospital, adding a 10-story tower and an additional 114 licensed beds. WVU Medicine has also opened a three story, 110,000 square foot ambulatory care facility to help address the growing demand for services. The Robert C. Byrd Health Sciences Center has a full complement of academic programs in the clinical and basic sciences.

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Kelli Piccirillo, Physician Recruitment, at piccirillok@wvumedicine.org.

WVUMedicine

For additional information, contact **Dr. Hassan Ramadan**, Professor and Chair, Department of Otolaryngology at **hramadan@hsc.wvu.edu** / 304-293-3233.

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

NYU Langone
MEDICAL CENTER

Chief of Service
Otolaryngology-Head & Neck Surgery
(Faculty Position)

The Department of Otolaryngology-Head & Neck Surgery at NYU Langone Medical Center invites applications for the position of Chief of Service, Otolaryngology-Head & Neck Surgery at NYU Lutheran Hospital located in Brooklyn, NY at the Assistant, Associate or Professor level. NYU Lutheran Hospital, Brooklyn is a major affiliate of NYU Langone Medical Center as part of the fully integrated network. This is an excellent opportunity to build a division of Otolaryngology-Head & Neck Surgery in one of the fastest growing cities in the U.S. This position includes full academic appointment at NYU School of Medicine, in the Department of Otolaryngology-Head & Neck Surgery. Candidate must be board certified/eligible and have experience with all aspects of general otolaryngology, as well leadership and team building capacity.

All interested candidates should submit their CV's and cover letters to: **Steven H. Schutzer, Administrator, Deptartment of Otolaryngology-Head & Neck Surgery, NYU Langone Medical Center, 550 First Avenue, NBV Suite 5E5, New York, NY 10016; Email: steven.schutzer@nyumc.org.**

EOE including Disabled and Vets VEVRAA Federal Contractor

Wheaton Franciscan Medical Group
All Saints

OTOLARYNGOLOGIST
WITH WHEATON FRANCISCAN MEDICAL GROUP

Wheaton Franciscan Medical Group is seeking an Otolaryngologist to join our practice in Racine, Wisconsin. The candidate must demonstrate specialty interest and training in outcome measures and quality. This position offers the unique opportunity to work in a community setting while preparing to assume the practice of one of our retiring Medical Group Physicians.

- Multispecialty Group comprised of 140+ B/C physicians
- Seeking BC/BE General Otolaryngologist to join one other B/C physician
- Well established practice on hospital campus
- Dedicated staff
- 230,000 patient base
- 3 Audiologists
- ABR & OAE equipped office
- Attractive salary/benefits package
- Established referral patterns with 60+ Primary Care Physicians
- Ideally located on the shores of Lake Michigan, 25 miles south of Milwaukee and 65 miles north of Chicago

Our Mission: We are committed to living out the healing ministry of Jesus by providing exceptional and compassionate healthcare service that promotes the dignity and well-being of the people we serve.

Interest and questions may be directed to:

Carol Kamenar
Sr. Physician Recruiter
262-687-6420
Carol.kamenar@wfhc.org

Full time Opportunity on Long Island (Port Jefferson, NY) as soon as June 1, 2016

ENT and Allergy Associates, LLP (ENTA), a collaborative practice of over 175 physicians in 42 offices throughout NY and NJ, is looking to add a board certified ENT to its rapidly expanding Long Island team. ENTA offers:

- ► A broad range of ENT, Allergy and Sub-Specialty Services
- ► A brand new state-of-the-art Port Jefferson clinical site, currently consisting of 7 ENTs and an Allergist
- ► A starting salary of $300,000
- ► A well-traveled road to partnership without buy-ins and buy-outs

For more information, please visit **entandallergy.com/careers/physician-opportunities** or **entandallergy.com/office/port-jefferson** or contact:

Robert P. Green, MD, FACS
President, ENT and Allergy Associates
rgreen@entandallergy.com

Robert A. Glazer
CEO, ENT and Allergy Associates
914-490-8880 ▪ rglazer@entandallergy.com

SOUTH FLORIDA ENT ASSOCIATES

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

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

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

This position will include both office and hospital settings.

Requirements:

Board Certified or Eligible preferred
MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
Current Florida license
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills
F/T - M-F plus call
For more information about us, please visit www.sfenta.com.

Contact Information:

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

University of Massachusetts Medical School
UMASS
UMassMemorial Medical Center

The Best Place To Get Care. The Best Place To Give Care.

Academic Otolaryngologist

Join an established group of 7 physicians in a busy tertiary care referral center. We are looking for dynamic new or recent graduates with energy, desire, and drive to jump start their careers and help expand our scope and presence. Opportunities exist for clinical and basic science investigation and research. An academic appointment commensurate with education and training is offered. Responsibilities include clinical care as well as student and resident education.

UMass Memorial Medical Center is situated in Worcester, MA, a community rich in history. Worcester is the second largest city in Massachusetts and New England, and has a very large patient referral base. Worcester and the surrounding area have a strong and diverse economic base with family oriented communities and excellent school systems. Boston and Providence are only forty miles away, and beaches, lakes, and mountains are all easily accessible.

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

Daniel Kim MD
Department Otolaryngology - Head and Neck Surgery
UMass Memorial Medical Center
c/o Melissa Miller, Physician Recruiter
Email: melissa.miller3@umassmemorial.org
Phone: 774-443-2980

As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.

A position is available at the Assistant or Associate Professor level in the Department of Otolaryngology/ Head & Neck Surgery

NEUROTOLOGIST/OTOLOGIST

- Rank commensurate with experience
- Excellent resources are available in this rapidly expanding program
- Fellowship training required

To apply and receive additional information about the support associated with this opportunity, please contact:

Stil Kountakis, MD, PhD, Professor and Chairman
Department of Otolaryngology-Head & Neck Surgery
1120 Fifteenth Street, BP-4109, Augusta, Georgia 30912-4060

Or email skountakis@gru.edu

Augusta University

Augusta University is an Equal Opportunity, Affirmative Action and Equal Access employer.

Full time Opportunity in Orange County (Middletown, NY) for a laryngologist as soon as June 1, 2016

ENT and Allergy Associates, LLP (ENTA), a collaborative practice of over 175 physicians in 42 offices throughout NY and NJ, is looking to add a board certified/fellowship trained laryngologist to its rapidly expanding Hudson Valley team. ENTA offers:

- ► A broad range of ENT, Allergy and Sub-Specialty Services
- ► A state-of-the-art Middletown clinical site, currently consisting of 5 ENTs and an Allergist
- ► A starting salary of $300,000
- ► A well-traveled road to partnership without buy-ins and buy-outs

For more information, please visit **entandallergy.com/careers/physician-opportunities** or **entandallergy.com/office/middletown** or **contact:**

Robert P. Green, MD, FACS
President, ENT and Allergy Associates
rgreen@entandallergy.com

Robert A. Glazer
CEO, ENT and Allergy Associates
914-490-8880 ▪ rglazer@entandallergy.com

Washington University in St. Louis
SCHOOL OF MEDICINE

Department of Otolaryngology-Head and Neck Surgery

Rhinology
The Department of Otolaryngology-Head and Neck Surgery invites applications for a full time faculty position at the Assistant or Associate Professor level on the Clinician/Educator or Investigator track. Fellowship training and/or extensive experience in rhinology and anterior skull base surgery is required. This position carries a full academic appointment at Washington University School of Medicine. Clinical responsibilities will include inpatient and outpatient responsibilities within the Department of Otolaryngology at Barnes-Jewish Hospital and St. Louis Children's Hospital, supervision of residents and medical students, as well as teaching and interdisciplinary collaborations in a very supportive and stimulating academic department. Opportunities for independent and collaborative research are available depending on individual qualifications. Candidates must be board certified or eligible for certification.

Otology/Neurotology
The Department of Otolaryngology-Head and Neck Surgery is accepting applications for a full time faculty position at Washington University School of Medicine at the Assistant or Associate Professor level on the Clinician/Educator or Investigator track. Candidates must have fellowship training in Otology/Neurotology and be board certified or eligible for general and subspecialty certification. Clinical responsibilities will include inpatient and outpatient responsibilities at Barnes-Jewish Hospital and St. Louis Children's Hospital, supervision of residents and medical students, as well as teaching and interdisciplinary collaborations in a very supportive and stimulating academic department. Opportunities for independent and collaborative research are available depending on individual qualifications.

Applicants may send their curriculum vitae to: Craig A. Buchman, MD, FACS, Lindburg Professor and Head, Department of Otolaryngology-Head & Neck Surgery, Washington University School of Medicine, 660 South Euclid Avenue, Box 8115, St. Louis, MO 63110 or buchmanc@ent.wustl.edu.

Washington University is an affirmative action and equal opportunity employer.

BARNES-JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians | Children's Hospital · St. Louis

ENT PHYSICIAN

SOUND HEALTH SERVICES, P.C.

One Group. Sound Health. Complete ENT Care.

Sound Health Services, a twenty-three physician Otolaryngology group in St. Louis, MO, has an immediate opening in their South County practice. Sound Health Services is the largest independent ENT group in the St. Louis metropolitan area. We provide full service ENT care including Audiology, Vestibular Testing, Hearing Aid Dispensing, Voice & Swallowing Services, Facial Plastics and CT Scanning.

We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance, and CME reimbursement, plus other benefits. Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hard working.

Requirements:

- **Board certified or eligible**
- **MD/DO from approved medical/osteopathy school**
- **Excellent communication and interpersonal skills**
- **Graduation from accredited residency program in ENT**

For more information about this position, please contact our Practice Manager, Rebecca Akers, at 314-843-3828, or by email at **bakers@soundhealthservices.com**.

You may also visit our website at **soundhealthservices.com**.

arches

An Open Letter to the American Academy of Otolaryngology:

Arches Natural Products appreciates the AAO's important role in the ENT community. However, we respectfully disagree with your recent recommendation against Ginkgo biloba for treating tinnitus patients. Rather than focusing on the standardized extracts with positive clinical evidence, the recommendation accepts the results of studies using inferior extracts – citing less credible research as grounds for dismissing more credible research.

All RCTs conducted with the higher-quality, standardized ginkgo extract EGb 761 demonstrated positive results as compared with placebo or reference drugs.

Holstein conducted a meta-analysis of 19 clinical studies using EGb 761[1]; eight of these used placebo or reference drugs. Von Boetticher conducted a systematic review of eight RCTs using EGb 761.[2] In all cases, this form of ginkgo extract proved superior to placebo or reference drugs.

The AAO dismissed these studies, citing two other meta-analyses. In one of these, Rejali, Sivakumar, and Balahi pooled studies using ginkgo products of different and partially unknown qualities. In the other, Hilton, Zimmerman, and Hunt included three clinical trials with three different products. Von Boetticher's systematic review rejected both these analyses due to the unknown quality of the extracts.

Credible research has shown that Ginkgo biloba extract EGb 761 helps reduce tinnitus. The proprietary ginkgo extract used in Arches Tinnitus Formula® meets and exceeds EGb 761 in purity and potency. A Certificate of Analysis is available on request.

We invite all otolaryngologists to view the clinical evidence and decide for themselves. **Please visit our website or contact us to request a Physicians Booklet and clinical studies.**

Respectfully,

Arches Natural Products, Inc., est. 1998
800-350-8981
md@archesnp.com
www.tinnitusformula.com/md

1. Holstein N. Ginkgo special extract EGb 761 in tinnitus therapy: An overview of results of completed clinical trials. *Fortschr* Med 2001 Jan 11; 118(4): 157-64.

2. Von Boetticher A. Ginkgo biloba extract in the treatment of tinnitus: a systematic review. *Neuropsychiatr Dis Treat* 2011; 7:441-447.

THE MORE

DIFFICULT THE CASE,

THE LESS DIFFICULT THE CHOICE

OF HOSPITAL.

The Department of Otolaryngology – Head and Neck Surgery at The Mount Sinai Hospital is a world leader in the treatment of HPV-associated oropharyngeal cancers, using robotic surgery to deescalate therapy and reduce toxicity. We are widely recognized for our Facial Plastic and Reconstructive Surgery expertise, as well as our innovative Skull Base Surgery Center. Additionally, our experts are on the faculty of the Icahn School of Medicine at Mount Sinai, ranked among the nation's top 20 medical schools by *U.S. News & World Report*, and the Head and Neck Cancer Research Program is the foremost international resource for tumor dormancy.

- Head and Neck Institute
- Center for Hearing and Balance
- Center for Thyroid and Parathyroid Diseases
- Eugen Grabscheid MD Voice Center
- Skull Base Surgery Center
- Sleep Surgery Program

Mount Sinai *New York*

1-800-MD-SINAI • mountsinai.org/msent