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

MARCH 2017

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Voice Committee
Members respond to common questions 20

Clinical Practice Guideline:
Benign Paroxysmal Positional Vertigo (Update) 27

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

bulletin

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CALL FOR PAPERS

Otolaryngology-Head and Neck Surgery

is seeking papers from medical students, residents, and young physicians under 40 years of age for a themed issue to be published in fall 2017.

The issue will showcase articles with medical student, resident, and young physician first authors across the range of topics in otolaryngology–head and neck surgery. All article types are appropriate for submission.

Submit papers for the themed issue at **www.editorialmanager.com/otohns**. Choose the manuscript classification "Authors Under 40 Themed Issue" on the "Select Classifications" page when submitting.

Deadline for submission to be considered for this special issue is

May 1, 2017

Accepted papers may be published in the themed issue or a standard issue at the Editors' discretion.

If you have any questions, please contact the Editorial Office at **otomanager@entnet.org**.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

The otolaryngologist as endocrine surgeon

Otolaryngology is an amazingly diverse specialty, extending from medical treatment of allergies to a wide-range of pediatrics, and from otology/neurotology/skull base surgery to head-neck surgery, and now, thyroid and parathyroid endocrine surgery of the neck. One must keep in mind the high prevalence of hyperparathyroidism in our patient population. For most of the adults we see in our office, there is a 50 percent prevalence of thyroid nodular disease.

We now recognize within otolaryngology-head neck surgery the discrete subspecialist: *otolaryngologist as thyroid and parathyroid neck endocrine surgeon.*

There is a history here. In 1883 Professor Theodor Kocher, father of modern thyroidectomy, presented his historic paper describing the adverse effects of un-supplemented total thyroidectomy (termed cachexia strumiprivia) to the Fifth German Surgical Congress. At about this time, Sir Felix Semon, MD, a Prussian otolaryngologist, also suggested in a meeting of the Clinical Society of London, similarities between English myxedematous patients and patients who had undergone total thyroidectomy.[1]

An ideal training background for a thyroid and parathyroid neck surgeon is a typical otolaryngology residency. Such training optimally positions the surgeon for a career in thyroid and parathyroid surgery given the depth of training in head and neck surgical oncologic treatment, understanding of recurrent laryngeal nerve and laryngeal anatomy and function, and assessment of nodal disease and its treatment. It is important that we articulate this unique set of skills of the otolaryngologist to patients, and to program directors, and individuals in hiring positions in large otolaryngology groups. It is equally important to articulate this discrete species of otolaryngologist to our trainees, residents, and fellows. **David Goldenberg, MD,** and **Ralph P. Tufano, MD,** have led over several years high-quality educational initiatives on behalf of the AAO-HNSF and American Head and Neck Society (AHNS) for residents and fellows to meet this very need.

Perhaps the first stop in endocrine surgical activities is our **Endocrine Surgery Committee,** recently designated as a Model Committee. Past chairs include myself and the late **Robert A. Sofferman, MD.** The committee is led by Dr. Tufano, who has done a tremendous job mentoring dozens of young surgeons in this field. We will be in excellent hands with **David L. Steward, MD,** who oversees the expansion of our website patient materials, including videos relating to endocrine surgery.

The Academy has written the first surgical guideline[2] relating to recurrent laryngeal nerve management and voice optimization at the time of thyroid surgery. The Academy's activities have also extended to important endocrine liaisons including participation in the American Thyroid Association's thyroid nodule and thyroid cancer guidelines[3], whose authors included two Academy members. **Miriam N. Lango, MD,** and **Kevin T. Brumund, MD,** spearheaded the Academy's liaison with ThyCa, a national thyroid cancer survivors group.

Important position statements relating to endocrine surgery have recently been authored. **Mark E. Zafereo, Jr., MD,** led a position statement on SPECT/CT for preoperative parathyroid surgical imaging and Dr. Steward led the position statement on surgeon-performed ultrasound. Many of the papers referenced in this position statement were authored by him and **Lisa A. Orloff, MD.**

The AAO-HNSF 2016 Annual Meeting included 14 endocrine surgical Instruction Courses and seven endocrine surgical Miniseminars ranging from complications in thyroid surgery, to finding the hidden parathyroid adenoma, to thyroid cancer in Korea versus U.S., to molecular analysis of thyroid nodularity.

David J. Terris, MD, is chair of the new AHNS Endocrine Section, which is also broadening otolaryngologic endocrine surgical initiatives, including endocrine surgical fellowships. The initiatives within the AHNS are significant and include the recent superb invasive thyroid cancer guidelines[4] led by **Maisie L. Shindo, MD.** ■

Gregory W. Randolph, MD
AAO-HNS/F President

> "An ideal training background for a thyroid and arathyroid neck surgeon is a typical otolaryngology residency."

References

1. Randolph GW (Ed). Surgery of the Thyroid and Parathyroid Glands. 2nd edition. 2013. Philadelphia, PA: Elsevier Saunders , p 6.
2. Chandrasekhar S, Randolph GW, Seidman MD, et al. Clinical Practice Guideline: Improving Voice Outcomes after Thyroid Surgery. *Otolaryngol* Head Neck Surg. 2013 Jun;148(6 Suppl): S1-37.
3. Haugen B, Alexander E, Bible K, et al. 2015 American Thyroid Association Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer. *Thyroid*. 2016 Jan;26(1):1-133.
4. Shindo M, Caruana SM, McCaffrey J, et al. Management of invasive well-differentiated thyroid cancer: an American Head and Neck Society Consensus Statement. *Head Neck*. 2014 Oct;36(10):1379-1390.

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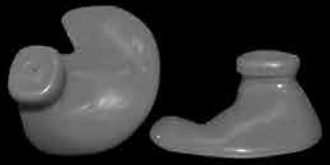

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Speaking up for physician well-being

The American Council for Graduate Medical Education (ACGME) recently released recommendations related to the 80-hour work week for resident trainees. The Academy and other organizations within the specialty made recommendations to the ACGME and were quite pleased with their proposals to increase flexibility in surgical residency training programs while maintaining safeguards for patient safety and resident well-being. This is a great example of how collaborative efforts within the specialty and the house of medicine can result in a favorable outcome for all.

It is no secret that daily the practice of medicine, as well as that of other healthcare professions, is becoming more complex and stressful. A "healthy" workforce is critical to optimizing care for patients. "Physician burnout" has far-reaching implications in the United States healthcare delivery system. Medical errors have been shown to increase significantly and patient satisfaction decline substantially as the burnout phenomenon increases. While physician well-being is not a new topic, it has expanded greatly since the "resident syndrome" was recognized in the 1970s. Currently, it is estimated that greater than 60 percent of the physician workforce experiences burnout. This is more than two times the rate of the general population and is increasing persistently. The resultant depression, substance abuse, and suicides are reaching crisis proportions, and clearly the situation will require the collaborative intervention of all stakeholders in healthcare delivery.

I recently participated in the National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience in Washington, DC. Participants included representatives from medical associations, the nursing community, the ACGME, the Accreditation Council for Continuing Medical Education (ACCME), government and private payers, the American Hospital Association, the Federation of State Medical Boards, the American Board of Medical Specialties, the National Patient Safety Foundation, the Agency for Healthcare Research and Quality (AHRQ), large healthcare systems, and the Surgeon General of the United States. This group has committed to work together to heighten awareness of the serious nature of this issue as well as identify and modify both internal and external factors that combine to worsen the current situation.

This process will require a commitment of resources from all stakeholders to identify, research, and catalog the underlying systemic and individual components responsible for creating the current state of affairs regarding clinician well-being. A number of significant systemic issues face providers today led by a plethora of electronic health records concerns but also including healthcare delivery system changes, payment changes, and the expanding excess of regulatory requirements, with more alterations expected under the new Administration. There is also the formidable task of changing the "culture" that physicians and nurses navigate currently. This culture of self-neglect and denial only tends to perpetuate and intensify the problem. The Academy looks forward to working with this collaborative effort led by the NAM to improve the lives of our Members through changes to the system and educational efforts to positively affect the day-to-day practice of medicine.

World Voice Day (April 16) materials are available at http://www.entnet.org/WorldVoiceDay. It is time to extend the reach of the message, "share your voice," and highlight the crisis healthcare providers are facing today.

International programs

Your president, **Gregory W. Randolph, MD**, has been leading our efforts along with our distinguished international team to operationalize the ongoing upgrade to our international programs being rolled out at our AAO-HNSF 2017 Annual Meeting & OTO Experience in Chicago. Considerable time and effort are being spent to ensure the successful launch of our International Advisory Board (IAB) this fall in Chicago. The inaugural chair and vice-chair of the IAB, **Johan Fagan, MD,** and **Sady Selaimen da Costa, MD, PhD,** are actively involved with Academy leadership including Dr. Randolph and the international coordinator, **James E. Saunders, MD,** and coordinator-elect, **J. Pablo Stolovitzky, MD,** in formulating the goals and operational parameters for the IAB. We will offer CME at the International Symposium under the direction of **Mark K. Wax, MD,** at the Annual Meeting, and we continue to expand our education portfolio for distribution to otolaryngologists worldwide. ■

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

> "Greater than 60 percent of the physician workforce experiences burnout. ... The resultant depression, substance abuse, and suicides are reaching crisis proportions."

BOARD OF GOVERNORS

The power of communication

Susan R. Cordes, MD
Chair, BOG Legislative Affairs Committee

Recently, I was watching a television show set during the reign of Louis XIV of France (1643-1715). King Louis XIV started bleeding and requested his physician. The next scene shows a gentleman at the physician's home relaying the request and escorting her to the king. In those days, if you wanted to communicate with someone, you had to find that person and relay the message. It's pretty safe to say that communication has come a long way, and much of that progress has been very recent. Our parents and grandparents dealt with cumbersome corded telephones and expensive long distance service, and just a generation or two removed, we carry not only a telephone but a computer with us everywhere we go. I have to remind myself sometimes that widespread internet use, mobile phones, and social media are all products of the last quarter of a century.

Next month, we celebrate World Voice Day, and while naturally the focus is on "Voice," one cannot ignore the importance of "World." Thanks in large part to ease of communication, everything we do/say/tweet has the potential to be on a global scale. Our Academy embraces the global nature of otolaryngology with a host of international programs. The International Steering Committee has regional directors responsible for communicating with International Corresponding Societies in every corner of the world. The newly formed International Advisory Board provides a structure and a voice for our valued international colleagues, and the Humanitarian Efforts Committee fosters volunteer otolaryngology in low resource settings. Any Academy Member interested in these or other international offerings is encouraged to learn about and participate in these programs.

Now more than ever, it is easy to connect with colleagues across the United States and across the globe. Involvement in international otolaryngology can be an enormously rewarding experience. It is exciting to share ideas and learn from our colleagues around the world. I personally had the good fortune to attend the All Africa ENT and Audiology Congress in Rwanda last year, which provided the opportunity to learn about otolaryngology across the African continent. This year, I look forward to the exciting International Federation of Oto-Rhino-Laryngological Societies (IFOS) World Congress. Paris in June—what could be better than that!

The ability to communicate is a gift. The theme of this year's World Voice Day is "Share Your Voice," see page 16. The Academy and the Board of Governors offer so many options for making your voice heard. Take a moment to explore those options and find the right medium for you. By using the tools we have at hand to share and connect with our colleagues in the U.S. and abroad, we demonstrate our appreciation for that gift. In the process, we are likely to grow as otolaryngologists and human beings in ways that we may not have imagined. ■

“If all my possessions were taken from me with one exception, I would choose to keep the power of communication, for by it I would soon regain all the rest.”

Daniel Webster

How to calculate your honor points

Honor points, Honors Awards, and Distinguished Service Awards are all part of the Academy and Foundation's system of recognizing Members for volunteer activities. The honor point promotes recognition not only for the quality of service, but also for the variety and longevity of service. Non-members receive honor points but are not eligible for Honors Awards or Distinguished Service Awards. However, points earned as a non-member convey once a non-member becomes an AAO-HNS Member.

How Members earn honor points

Members receive honor points for participating in a variety of activities and leadership roles, including:

- Academy and/or Foundation committee
- Annual Meeting course instructor, paper presenter, or poster presenter
- BOG committee
- BOG Spring Meeting attendee
- CORE Study Section grant review
- Exceptional service on a committee, upon recommendation by the chair
- Guideline Development Task Force
- Officers and members of the Board of Directors
- Editorial Boards and Associate Editors of AAO-HNSF journals
- Presidential-appointed ad hoc task force members

Honors Award

The Honors Award is the first award a Member can obtain for participation in activities that earn honor points. Each Member can only earn one Honors Award in a lifetime. To receive an Honors Award, a Member must earn 10 volunteer service honor points over a minimum of five years. A maximum of two points, each from a different category of service, can be earned per year.

Here are the basic rules for calculating points for the Honors Award:

1. Ten honor points are required to earn the award.
2. No more than two points per year are credited to the award.
3. No more than one point per category, per year, can be credited to the award; therefore, to earn the maximum of two points per year, a Member must participate in two different qualifying activities.
4. It takes a minimum of five years to earn the Honors Award.

Distinguished Service Award

The Distinguished Service Award is the recognition of volunteer service beyond the level of an Honors Award. Members who attain 50 honor points, including the 10 points received for an Honor Award, receive the Distinguished Service Award (DSA).

There is no limit on the number of Distinguished Service Awards a Member may receive. All honor points, regardless of quantity earned in each category in a year, are credited toward the DSA. For example, if Dr. Doe teaches two instruction courses, two points are credited to the DSA. However, only one of these points can be applied to an Honors Award.

Visit **http://www.entnet.org/content/member-engagement-points** to see examples of points calculations.

Alphabet Soup: Acronyms you need to know

Ever read an article, have a conversation, or watch a news program that includes myriad acronyms that cause a "what does that mean" moment? Get some answers by reviewing the compilation of acronyms below.

APM: Alternative Payment Model. APMs are a type of payment reform incorporating quality and total cost of care into reimbursement rather than a traditional fee-for-service structure. Eligible clinicians who successfully participate in a CMS-defined Advanced APM may be exempted from MIPS reporting (see below) and receive a five percent incentive payment.

CBO: Congressional Budget Office. CBO produces independent analyses of budgetary and economic issues to support the Congressional budget process. CBO "scores" proposed bills to help lawmakers understand the cost or savings associated with a legislative package.

CHHC: Congressional Hearing Health Caucus. CHHC is a bipartisan caucus of members from the U.S. House and Senate committed to supporting the needs of people with hearing loss and other auditory disorders. The AAO-HNS is a member of the Friends of the CHHC.

CMS: Centers for Medicare & Medicaid Services. CMS is a federal agency within the U.S. Department of Health and Human Services. It is responsible for administrating the Medicare program and working with states on administrating their Medicaid programs.

EHDI: Early Hearing Detection & Intervention. EHDI is a critical program that supports statewide plans identifying infants/children with hearing loss and directing them to early intervention services. The AAO-HNS is working with the hearing health community to advance legislation in the 115th Congress to reauthorize the federal portion of the EHDI program for an additional five years.

HIT: Health Information Technology. Software and computer systems now make medical records electronic, reducing paperwork and redundant forms. Federal and state governments are implementing numerous proposals to encourage the adoption of HIT, while promoting quality initiatives and protecting patient privacy.

MACRA: Medicare Access and the Children's Health Insurance Program (CHIP) Reauthorization Act. MACRA repealed the Sustainable Growth Rate (SGR) formula that Medicare previously used to determine physician reimbursement. The program comprises two tracks: Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM).

MedPAC: Medicare Payment Advisory Commission. MedPAC is an independent federal body established by the Balanced Budget Act of 1997, responsible for advising Congress on topics within the Medicare program, and more specifically, on issues dealing with payments to private health plans participating in Medicare and health providers that serve Medicare beneficiaries.

MIPS: Merit-based Incentive Payment System. MACRA created the MIPS to replace the current CMS Quality Initiative Programs. MIPS incorporates aspects of several CMS quality programs into a component score to determine physician payment. Eligible clinicians will report on three categories that will add up to a composite performance score (CPS).

NAM: National Academy of Medicine. NAM was established in 1970 as the Institute of Medicine (IOM) and works to address crucial issues in health, medicine, and policy. In June 2016, NAM published "Hearing Healthcare: Priorities for Improving Access and Affordability," which highlights the importance of easier access and more affordable options for hearing healthcare. The AAO-HNS submitted comments to NAM prior to the report's release.

NIDCD: National Institute on Deafness and Other Communication Disorders. NIDCD is one of 27 Centers and Institutes that make up the National Institutes of Health (NIH) and conducts biomedical and behavioral research in the fields of hearing, taste, smell, voice, balance, language, and speech, supporting disease prevention and health promotion.

PAC: Political Action Committee. PACs allow individuals with shared interests the opportunity to pool their voluntary donations to make contributions to federal candidates on behalf of the entire group. PACs represent a legal and ethical way to participate in the election process. ENT PAC (www.entpac.org) is the political action committee of the AAO-HNS.

PCAST: President's Council of Advisors on Science and Technology. PCAST is an advisory group of the nation's leading scientists and engineers who directly advise the President and the Executive Office of the President. In 2015, PCAST released the report, "Aging America & Hearing Loss: Imperative of Improved Hearing Technologies."

TIA: Truth in Advertising. The AAO-HNS and others in the physician community support state and federal efforts to implement TIA legislation requiring ALL healthcare providers to inform patients of their credentials and/or level of training in patient communications and marketing materials. TIA is an important component to providing patients with the best possible care. ■

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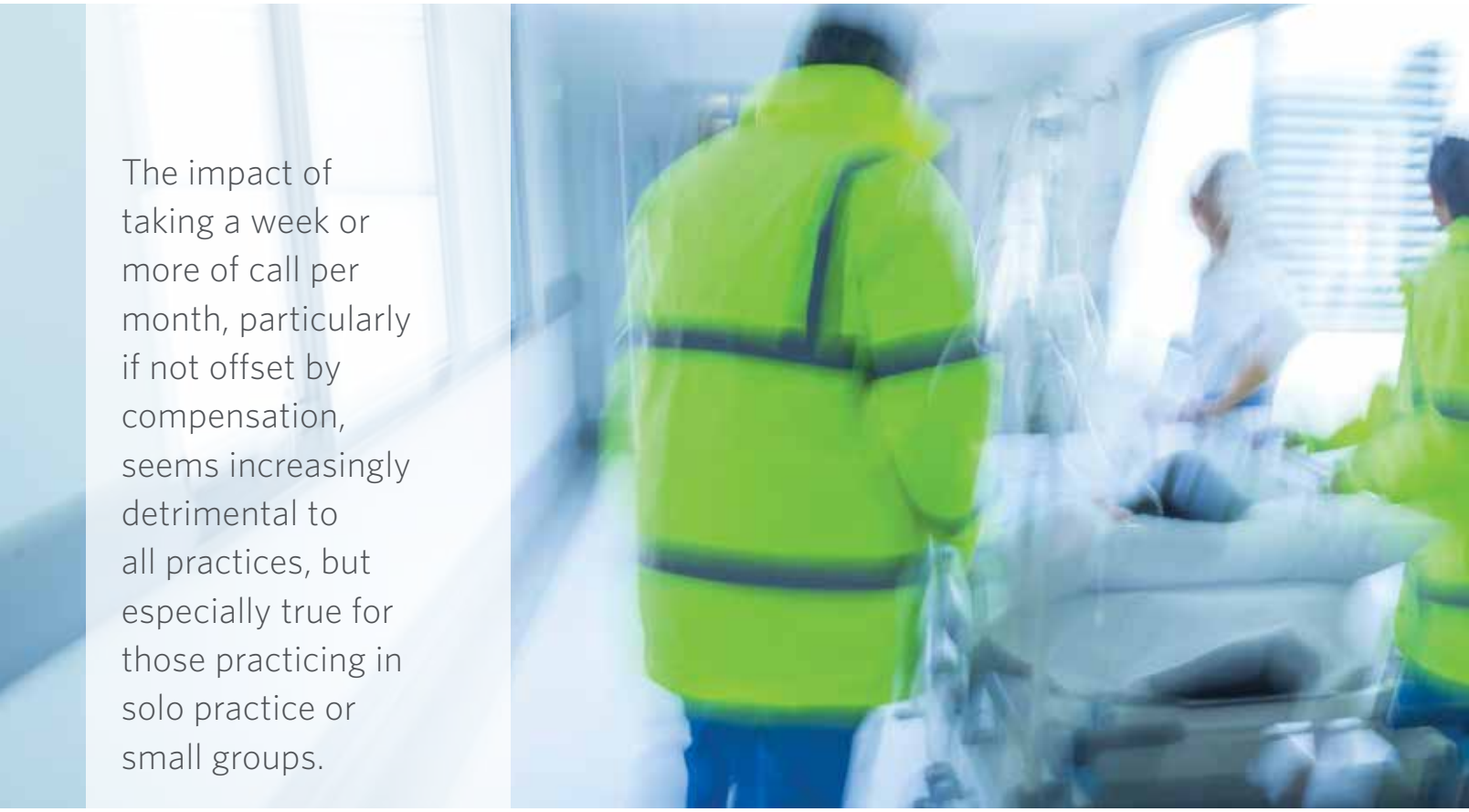
Emergency room call



The impact of taking a week or more of call per month, particularly if not offset by compensation, seems increasingly detrimental to all practices, but especially true for those practicing in solo practice or small groups.

While there has been a significant shift to outpatient locations for much of the scope of otolaryngology, many hospitals and institutions still require provision of emergency services as a requirement of medical staff membership. As part of the Board of Governors' (BOG) mission to identify and communicate issues for and with Academy Members, a survey was disseminated to BOG society members on the impact of emergency room (ER) call. The BOG hoped to gather data to identify any issues or concerns, and allow Members to compare their situations with their peers.

We had a record response rate of 677 participants from across the nation. The results of the survey highlight several challenges and areas of concern.

The majority (almost 90 percent) are required to take ER call for non-practice patients. This requirement is typically specified by either hospital bylaws or department rules and regulations, although almost 20 percent were required to take call by their employer or group. Despite the broad call requirement, two-thirds of respondents are not compensated for this service or the costs they incur. These costs include follow-up care, not only the cost of un- or undercompensated care, but also the direct and indirect costs incurred from no show or cancelled appointments, bumping of existing patients, and administrative costs of contact, follow-up, and insurance authorization.

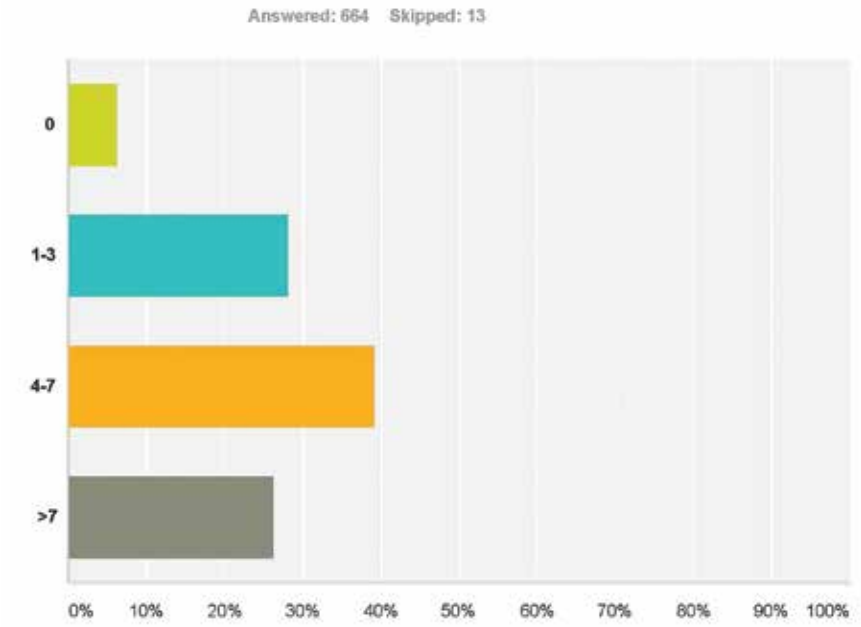
Of those respondents who were compensated, 46 percent were paid with a per diem rate, and 20 percent were paid through a weekly, monthly, or yearly stipend. Almost one-third of respondents commented on their

survey results

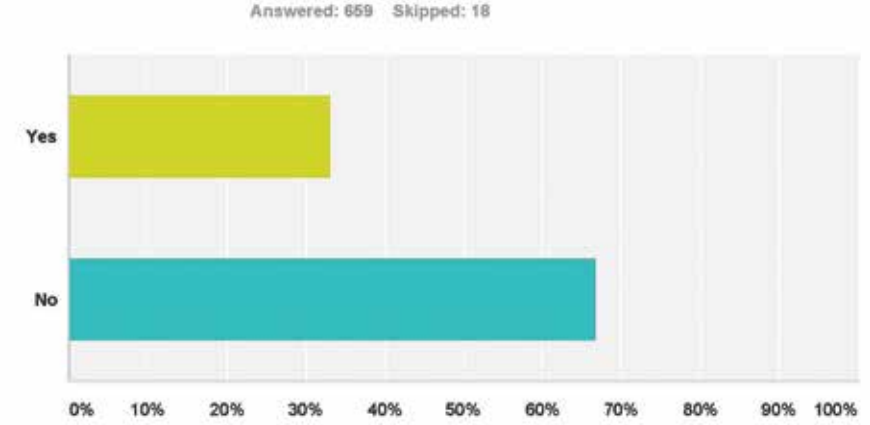
personal arrangements, with reimbursement ranging from a low hourly rate to a daily rate, with most reporting to be in the middle of that range.

Unlike some specialties, otolaryngologists have not widely negotiated successful, significant on-call compensation, and unfortunately, there is little specialty-specific information available. There are two proprietary surveys published, but these surveys contain limited otolaryngology-specific data, thus making it difficult to evaluate and negotiate appropriate call compensation. We originally hoped to

How many days per month do you take call?



Are you paid by a hospital to take your ER call?



“Thirty percent of respondents do not take any trauma call, approximately 20 percent cover all the trauma at their institutions, and the rest share trauma call with other specialties, which typically include some combination of plastic surgery and/or oral and maxillofacial surgery.”

collect more specific information on this topic via this survey, but due to antitrust concerns, this was not possible. The data and responses gathered in this survey clearly highlight the need for more accurate and complete information on this topic.

Our results also seem to indicate that institutions craft their transfer policies to minimize possible Emergency Medical Treatment and Labor Act (EMTALA) violations. However, there are concerns that this fails to consider variations in physician expertise, credentialing, and scope of practice. Sixty percent of respondents reported that their hospitals accept EMTALA transfers without consulting or notifying the on-call otolaryngologist, which may result in acceptance of transfers without the input of the call physician who will provide the care. This potentially may lead to clinicians faced with situations outside their expertise and comfort zone, or worse, a request to consult where they do not have the necessary privileges or credentialing. And, in this situation, almost 70 percent of respondents reported that their institution did not back them up when they expressed discomfort regarding a transfer. Further, such transfers fail to take into account the current status of the physician's workload, including the potential of already being fully engaged in on-call care, as well as the availability of other necessary resources such as the operating room, intensive care, and consultants in other specialties.

Additional concerns surfaced regarding the request for provision of care in areas outside our primary areas of practice (i.e., pediatrics for those who do not see children in their regular practice). Survey respondents noted that 75 percent do not have subspecialty ER call at their institutions, and that subspecialty call schedules exist primarily at large or academic centers. This results in general otolaryngologists being asked to cover specialty-level issues while subspecialists are required to cover general otolaryngology call problems, with both scenarios ending in a general level of discomfort.

Overall, 30 percent of respondents do not take any trauma call, approximately 20 percent cover all the trauma at their institutions, and the rest share trauma call with other specialties, which typically include some combination of plastic surgery and/or oral and maxillofacial surgery. There were many comments regarding the multiple arrangements covering trauma. For those who do cover trauma, there was a high level of discomfort suggesting another area of significant Member concern.

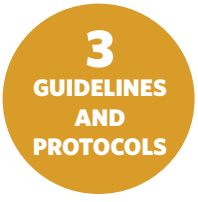
When queried regarding the amount of ER call required to provide, responses were fairly evenly split between those taking one to three days, four to seven days, and more than seven days per month. The impact of taking a week or more of call per month, particularly if not offset by compensation, seems increasingly detrimental to all practices, but especially true for those practicing in solo practice or small groups. While a few respondents did not feel their care of indigent patients was a burden, the majority found it a significant problem, which is getting worse.

The survey suggests three other areas where further information and support would be valuable:

- The development of a third-party database or broader survey tool of ER call would provide valuable information to guide appropriate and cost-effective care for these patients. Ideally, information regarding on-call compensation and related requirements, including age, length of service, and number of call days required, would be beneficial.

- The development of an organized transfer system to facilitate appropriate and timely care with clear protocols for communication between the transferring and receiving institutions would ensure appropriate resources and skill sets are in place *prior* to transfer. This would ideally include physician-to-physician contact and involve all services likely to participate in care of the transferred patient. For example, verification that interventional radiology is available for a patient with a severe nosebleed that might require embolization in addition to ligation, as well as packing of the nasal cavity prior to transferring that patient.

- The development of guidelines and protocols for ER departments to follow for specific conditions to help distribute the workload across overlapping specialties and avoid disagreements regarding responsibility. For example, at some institutions, isolated



orbital floor fractures without orbital rim or medial orbital wall components are handled by oculoplastic/orbital surgery. Otolaryngology is called only if there is medial wall or rim involvement. Similar protocols can be developed for other scenarios that reflect the skill sets and interests of the practitioners involved at any institution.

Unfortunately, the conflict between provisions of EMTALA to accept transfers and the uneven distribution of otolaryngologists is a more difficult issue to address. In many outlying or smaller hospitals and more rural ERs, there are not enough otolaryngologists to provide 24/7 coverage of the ER. This means that patients are often transferred to institutions where physicians are mandated to provide call and accept transfers of care without compensation or consideration for optimal provision of care. This can impose a considerable burden on the accepting physicians and institutions. Ideally, regionally coordinated call that addresses medico-legal, workload, and financial components would make maximal and optimal use of resources that are becoming increasingly scarce. ■

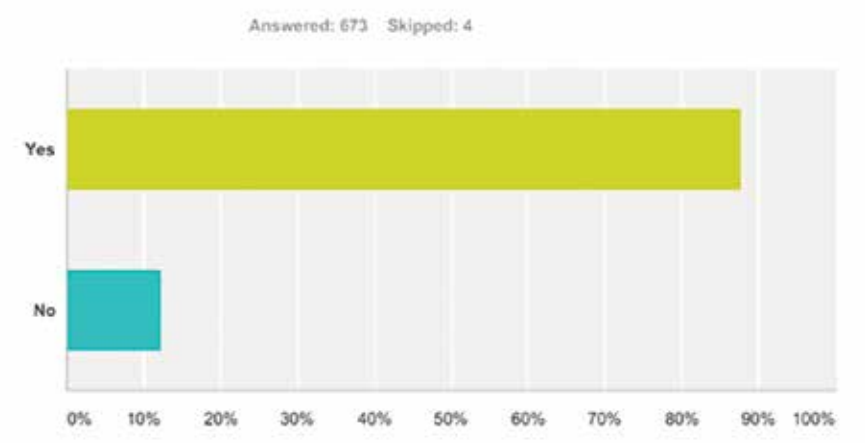
Thank you to those who participated in this latest BOG survey. It is our hope that discussion of issues such as these will lead to further dialog as we explore ongoing challenges and work together to develop potential solutions. Please continue to use the BOG as your grassroots voice of the Academy.

Hayes H. Wanamaker, MD
Chair, BOG Socioeconomic & Grassroots Committee

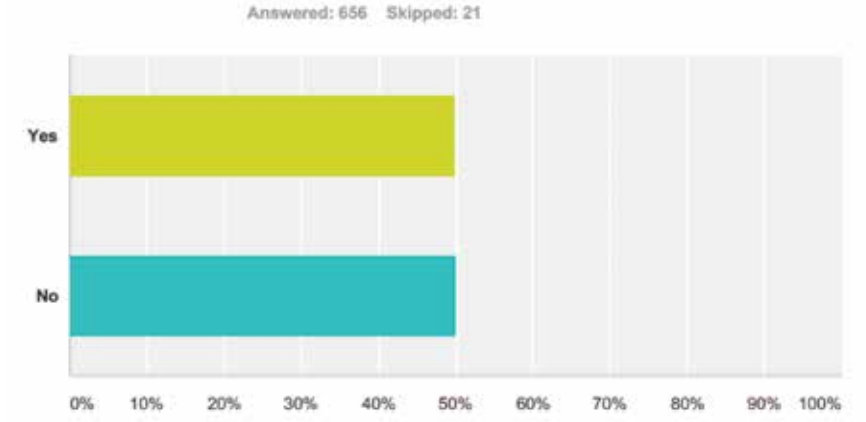
Lawrence M. Simon, MD
Vice Chair, BOG Socioeconomic & Grassroots Committee

Stacey L. Ishman, MD, MPH
Chair, BOG

Are you required to take call in your hospital ER for patients outside your practice?



Have you ever felt forced to provide care outside of your comfort zone due to ER call obligations?



Registration now open for the 2017 ENT for the PA-C Annual CME Conference

This continuing medical education activity is specifically designed for physician assistants, nurse practitioners, and medical professionals working in ENT, or interested in learning more about otolaryngology in primary care, urgent care, pediatric, and emergency room settings.

The ENT for the PA-C Annual CME conference is sponsored by the American Academy of Otolaryngology—Head and Neck Surgery and the Society of Physician Assistants in Otorhinolaryngology/Head & Neck Surgery (SPAO-HNS).

The conference will take place April 20-23 and is hosted by the Department of Otolaryngology of Northwestern Memorial Health Care in Chicago, IL. **http://www.entnet.org/content/ent-pa-c**

Share your voice

FROM THE AAO-HNS VOICE COMMITTEE

Spread the word about vocal health and hygiene to your community

by **Lyndsay Leigh Madden, DO**, Wake Forest University School of Medicine

According to the United States Census Bureau, as of December 30, 2016, the estimated population of the U.S. was more than 300 million, with the world population estimated at over seven billion. These more than seven billion human beings on our planet share their unique voices to creatively express emotion, inspire change, engage in conversation, and foster understanding. Today, in our fluctuating political climate, interpersonal communication is essential to bridging gaps and engendering empathy.

Regardless of our views or how we feel about important issues, our stories will never be understood unless we can effectively communicate our ideas and opinions. When we collaborate, we give others the opportunity to look at the world from a different perspective. Each of us has an inimitable story to tell; our perception of the world is

“The voice is paramount in sharing human stories, thoughts, and ideas, as it is a uniquely impactful medium by which to transmit knowledge and information and, most importantly, to develop relationships with one another.”

shaped by those we interact with, from the situations we were born into, and from the actions that we take throughout our lives. The more we share and listen to these disparate perspectives, the better we are able to reason, question, and contemplate issues that can ultimately shape our world now and in the future. The voice is paramount in sharing human stories, thoughts, and ideas, as it is a uniquely impactful medium by which to transmit knowledge and information and, most importantly, to develop relationships with one another.

On this **April 16, World Voice Day 2017**, I encourage you to take an introspective look

Download this 2017 World Voice Day Poster to hang in your waiting room. http://www.entnet.org/worldvoiceday

at the importance of vocal health and hygiene to daily life and communication, perspective, and empathy. As otolaryngologists, we have the unique opportunity to help people everywhere—from around the globe down to our local communities—-to better understand the importance of caring for the voice, partaking in healthy vocal behaviors, and being able to recognize when these vocal disturbances need to be further evaluated. Sharing otolaryngologic knowledge about vocalization and disorders associated with the larynx can ultimately have a substantial impact on public health.

Download the World Voice Day 2017 poster

Share this poster with your patients and spread the word about the importance of a healthy voice.Visit **www.entnet.org/worldvoiceday** to print your 2017 poster and access other World Voice Day resources.

1. Go to **www.entnet.org/worldvoiceday** to access the high-resolution print file.
2. Choose a size:
   - Small: 17.3" x 11.75"
   - Medium: 24" x 18"
   - Large: 36" x 24"
3. Upload the file to your local office supply store's website or save the file and take it to the store for printing.
4. Display in your office!

Here are a few vendors you may choose from:

- **print.staples.com/posters.aspx**
- **customprinting.officedepot.com**
- or try your drug store. ■

Sharing voice disorder identification within the medical community

One way in which we, as otolaryngologists, can promote vocal health in our own communities is to reach out to various medical societies to share information regarding voice disorder identification. Enlightening physicians in other fields about how to listen, not only to what patients are saying, but also to listen to how they are saying it, can be very beneficial. This sharing of information could potentially provide a safeguard for patients with voice disorders, keeping them from "slipping through the cracks," even if they do not think that they have a problem with their voice. Providing examples of how to recognize voice changes such as vocal roughness, pitch breaks, or tremor can assist providers in determining when an appropriate referral is warranted.

Sharing voice basics and mechanics with uber vocalizers

Another avenue for sharing information and increasing awareness about voice disorders is to engage in community outreach, particularly with groups whose voices are integral to their livelihood. This could include local performing arts elementary and high schools, community choral and theater groups, educators, or call centers. When meeting with these groups, vocal anatomy and also the physiology of voice production are potential topics of discussion.

As a laryngologist who frequently lectures to these specific groups, I often find it surprising how many people, who rely on their voice as their means of employment, do not know the mechanics behind it or what their larynx looks like. It is personally gratifying to show them how their "instrument" actually works. Important information that these groups might also benefit from includes material on common voice disorders, essential vocal health guidelines, and the basics of healthy speaking and singing technique. Partnering with our speech and language pathology colleagues for these outreach lectures can also be extremely valuable to the audience.

Overall, our goal as otolaryngologists, on World Voice Day and every day, is to encourage our patients to stay vocally healthy so that they may have a voice with which to express themselves and connect with others, thereby fostering understanding and empathy–vital components to our existence as human beings. ■

Vocal health tips to share with patients

- **Maintain a healthy lifestyle** that includes a balanced diet, 30-60 minutes of exercise daily, and restorative sleep.
- **Make sure to adequately hydrate** by consuming at least six to eight glasses of water daily to optimize laryngeal mucus production. During drier months, a personal humidifier may also help combat laryngeal dryness. Avoidance of caffeinated beverages and alcohol can also help prevent dryness and dehydration.
- **Stop smoking!** Smoking can cause significant irritation and swelling of the vocal folds that may permanently change voice quality. Smoking can also lead to laryngeal cancer.
- **Avoid overuse and abuse of the voice** by warming up before a period of heavy voice use, avoidance of yelling or screaming, and considering amplification if routinely speaking in loud environments or over background noise.
- **Watch for signs of vocal pathology.** Changes in the pitch, character, quality, tone, or vocal effort related to the voice may indicate a significant problem such as cancer, infection, or lesions. Share concerns with your physician, who may recommend a videostroboscopy to further evaluate your symptoms.

Voice Committee members offer responses to patients' most common questions on voice care

Featuring questions by **Libby J. Smith, MD,** with answers by **Sid Khosla, MD; Norman D. Hogikyan, MD; Julina Ongkasuwan, MD; Jeanne L. Hatcher, MD;** and **Reena Gupta, MD**

Q I don't sing, but I talk all day for my job. What does it mean to be a "professional voice user?"

A Sid Khosla, MD: Often people realize that vocal health is important to performers such as singers and actors; clearly if they lose their voice, they cannot function in their job. However, the term professional voice user includes anyone who uses their voice for their occupation, such as teachers, lawyers, call center workers, clergy, and fitness instructors. Unlike singers and actors, other professional voice users who lose their voice often say "I did not realize how important my voice was until I lost it." The risk for many voice disorders increases as a function of how much and how loud a person talks. For example, teachers are at high risk for vocal problems since they talk loudly (to be heard over significant background noise) most of the day. For teachers and any other professional voice users, missed work or unemployment can result from voice disorders due to increased voice usage. Therefore, it is important that all professional voice users, not just singers and actors, learn about ways to keep their voice healthy.

Q I become hoarse often, but my voice always recovers. Is there a problem with that?

A Norman D. Hogikyan, MD: This situation of a recurring but not chronic voice complaint is not unusual, and there are several common ways in which this can occur. In some cases, there is not actual laryngeal pathology as the root of the problem, but the individual is misusing or abusing their voice leading to the recurring symptoms. The symptoms may resolve temporarily when the misuse or abuse stops, but they recur when the poor voice behaviors resume. In other cases, there is actual chronic laryngeal pathology, often vocal fold mucosal lesions,

but the patient only notes symptoms when the pathology is aggravated by inflammation, excessive voice use, or other factors. Sometimes people with chronic mucosal lesions accept a basal level of dysphonia as their new normal and don't recognize that they are in fact always dysphonic to some degree. They may just accept an impaired voice-related quality of life (V-RQOL) until it reaches a moderate to severe degree of impairment. There are many other possible causes of a pattern of recurring hoarseness too, such as neurological problems, autoimmune disorders, or allergic stimuli. The bottom line point that I would like to stress is that recurring voice symptoms are a problem and do warrant an evaluation by an otolaryngologist or laryngologist. Once a diagnosis is determined, a tailored treatment approach can be implemented that will hopefully allow the individual to be free of voice problems long term and to freely "share their voice!"

Q I don't like drinking plain water but have heard it is important to stay hydrated. How can I best do this?

A Julina Ongkasuwan, MD: You may have heard the saying: "singers should not appear until their pee is clear." Vocal hygiene programs often focus on hydration as a cornerstone of vocal health. Fluid lubricates and alters the viscoelastic properties of the vocal folds, possibly protecting their surface from the impact stress of vocal fold vibration and decreasing vocal fatigue. Hydration can be systemic (by drinking fluids) or superficial (by breathing in the humidity of the air). Exactly how much fluid to drink varies between individuals depending on their activity level and other medications. Some blood pressure and allergy medications in particular may dry mucous membranes. Keep an eye on your urine, it should be clear or pale yellow.

But beware what you are putting in your cup—caffeine, found in coffees, teas, and sodas, is a diuretic that may cause further dehydration (though the exact effect on the vocal folds remains unclear); carbonated drinks may worsen reflux (which can in turn have a deleterious effect on the voice); and sugar can contribute to weight gain. So, what does that leave us with? Our old standby: water. If you do not like the taste of plain water, you can add the perennial singers' favorite, lemon and honey, or consider non-caffeinated teas or even mineral water. However, you must be cognizant of the sugar content of these beverages. While there is scant data, an alternative may be surface hydration with humidifiers or nebulizers, which may provide at least transient improvement in voice quality.

Q With all the new possible side effects attributed to proton pump inhibitors, what else can I do for my reflux symptoms?

A Jeanne L. Hatcher, MD: First I think it is important to make sure that your symptoms are caused by reflux. When it comes to throat irritation making a sensation of mucus or a lump in there, it could be from dehydration, allergies, or some combination of those. Having an otolaryngologist examine your larynx for signs of inflammation is important. If hoarseness is the main symptom from your reflux, stroboscopy will better examine the vocal cords specifically for reflux irritation. You can also discuss the role for reflux testing with your doctor as there are a couple of ways to do that. Before continuing or changing medical management, this may be helpful.

If reflux is confirmed, there are several options to treat this without relying on a daily medication. Avoiding large meals, eating before bedtime, fatty meals, alcohol, caffeine, peppermint, and chocolate are just a few of the dietary modifications you can try. For that great meal with a lot of reflux triggers, taking a proton pump inhibitor is a good option. Another family of medication for reflux are histamine receptor blockers or H2 blockers. Also, good for "as needed" reflux control is Gaviscon Advance®, a medication that helps make a barrier at the top of the stomach, reducing reflux from coming up. Remember too, that it is all about lifestyle and medication in moderation. If you have severe symptoms despite doing "all the right things," surgery may be an option. Discuss your symptoms in detail with your doctor to best manage that balance.

Q As I age, my voice sounds "old," becoming weak and raspy. Why is that and what can be done to help?

A Reena Gupta, MD: The changes that occur to the voice as we age can be very troubling. Our identity is closely tied to our voices and our relationships are built on them. Voice changes can therefore become a major barrier to socialization.

As we age, vocal musculature may atrophy, or thin. This results in either a softer closure or incomplete closure of the vocal folds. When this happens, the pitch of the voice changes, rising in men and falling in women. The effort required to use the voice also increases. It becomes tiring to speak for long periods of time, projection and shouting become more difficult, and speaking can become uncomfortable due to the effort it requires. These changes happen to varying degrees in each individual. While it may start early for some people, it may never occur to an appreciable extent in others.

Vocal therapy can help to decrease symptoms of vocal atrophy. If this is not successful in reducing symptoms satisfactorily, injections into the vocal muscle can restore bulk temporarily. This can significantly reduce symptoms. ■

Academy, Anthem collaborate on **new diagnostic fiberoptic flexible laryngoscopy** policy

Thanks to Academy physician leaders' comments and clinical recommendations, Anthem revised clinical coverage indications in their new diagnostic fiberoptic flexible laryngoscopy (FFL) medical policy.

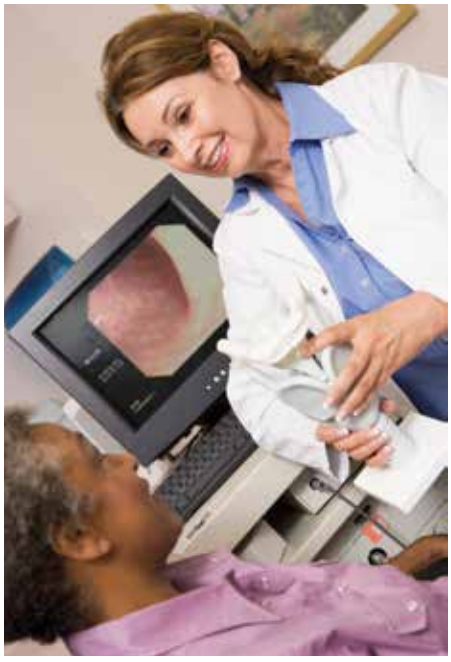
Key additions for initial treatment include:

- Diagnosis of symptomatic disorders involving the voice, swallowing, and upper aerodigestive tract, including obstructive sleep disorders;
- Preoperative evaluation of vocal cord function for individuals undergoing surgery where the recurrent laryngeal or vagus nerves are at risk of injury (for example, thyroid, anterior cervical spine, or carotid procedures);
- Further evaluation of abnormalities of the upper aerodigestive tract discovered by another modality, such as CT, MRI, bronchoscopy, or EGD.

Key additions for repeat procedures include:

- Assessing results of treatment for disorders involving the voice, swallowing, and upper aerodigestive tract, including obstructive sleep disorders;
- Surveillance for recurrence of tumors of the upper aerodigestive tract;
- Monitoring for growth or change of known lesions or disorders of the upper aerodigestive tract, which may or may not be subject to treatment;
- Postoperative evaluation of vocal cord function for individuals undergoing surgery where such function may be impacted, such as thyroid, anterior cervical spine, or carotid procedures.

Last summer, Anthem reached out to the Academy for assistance in developing and reviewing a new FFL medical coverage



policy. The Academy worked with the Airway and Swallowing Committee, Voice Committee, Head and Neck Surgery & Oncology Committee, and the Physician Payment Policy (3P) Workgroup to review the policy and provide feedback. The initial draft policy considered fiberoptic flexible laryngoscopy medically necessary for the diagnosis of symptomatic disorders involving the voice, swallowing, and upper aerodigestive tract, but lacked the necessary details in accurately treating a patient. After submitting a comment letter and discussing the policy in the fall with Anthem leadership, clinical recommendations were incorporated and are reflected in the new policy. Notable comments were made by **Robert Lorenz, MD, MBA, Jane T. Dillon, MD, MBA,** and **James C. Denneny III, MD.**

To learn more about this policy and other private payer advocacy achievements, visit **http://www.entnet.org/content/private-payer-advocacy.** ■

Health Policy Update morphs into podcast

Over the last few years, the Academy sent regular Health Policy Update emails to all practicing physicians in the United States. These regular HP Updates included all the Academy's regulatory and socioeconomic advocacy updates and provided Members with timely information and educational resources to keep them up-to-date on issues that affect their practice.

Starting in March, as part of the newly developed frequ**ENT**cy series, a podcast developed by the Academy, the HP Update will shift to a quarterly discussion on all regulatory and socioeconomic topics with Academy leaders and Members. The HP Update will provide direct access to leading health policy experts within the Academy, allowing Members to download and listen at their convenience.

Just in time for the AAO-HNS/F 2017 Leadership Forum & BOG Spring Meeting being held March 10-13 in Alexandria, VA, the March episode of the HP Update will feature discussions on the new Merit-based Incentive Payment System (MIPS) and how practices are preparing to report. **Robert Lorenz, MD, MBA,** and **Jane T. Dillon, MD, MBA,** leaders of the Physician Payment Policy (3P) Workgroup, discuss the ins and outs of 2017 MIPS reporting requirements. The HP Update also features a conversation with **Lance A. Manning, MD,** who provides insights on how his private practice is preparing for MIPS and how you can too.

You can listen to the HP Update and all frequ**ENT**cy podcasts by downloading the OTO Central App from iTunes or Google Play. ■

Academy **toolkit for MIPS reporting** in 2017

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 created the Quality Payment Program (QPP), containing two pathways for participation: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) program. Both payment programs began January 1, 2017. Under MIPS, eligible clinicians (ECs) will receive a composite performance score (CPS), which will determine if an EC will receive a bonus payment or be subject to a payment reduction. In 2017, the Centers for Medicare & Medicaid Services (CMS) will base an EC's CPS on reporting from three categories: Quality, Advancing Care Information (ACI), and Improvement Activities. To help Members with the transition, the Academy has developed this toolkit with participation requirements, opportunities to participate through Reg-ent℠, important dates to remember, and payment update information.

2017 MIPS participation requirements

All physicians, physician assistants, nurse practitioners, clinical nurse specialists, or certified registered nurse anesthetists who bill Medicare must participate in MIPS, unless they:

- **Have not previously participated in Medicare**
  - If 2017 is a clinician's first year participating in Medicare, then the clinician is not required to report to MIPS for the 2017 reporting period.
- **Do not meet the minimum reporting threshold**
  - ECs who bill Medicare for $30,000 or less in allowed Medicare charges **OR** see 100 or fewer Medicare Part B patients for a year are excluded from MIPS reporting for that year.
- **Are part of an Advanced APM**
  - ECs who receive 25 percent of Medicare payments or see 20 percent of their Medicare patients through an Advanced APM in 2017 are excluded from MIPS reporting for that year.

Reg-ent and 2017 MIPS participation

Reg-ent is an otolaryngology-specific clinical data registry, through which participants will be able to report the required MIPS categories, including Quality Measures, Advancing Care Information Measures, and Improvement Activities. Sign up by July 15, 2017, to make Reg-ent your MIPS reporting partner! Learn more about Reg-ent here: **www.entnet.org/reg-ent.**

Important dates for MIPS

During the 2017 MIPS performance period, there are several key dates and deadlines for ECs and groups:

- **January 1, 2017:** The first performance period opens.
- **July 15, 2017:** Reg-ent enrollment deadline to report MIPS 2017.
- **October 2, 2017:** To be eligible for the maximum positive payment adjustment in 2019, ECs must begin MIPS reporting before this date.
- **December 31, 2017:** The first performance period closes.
- **March 31, 2018:** ECs must submit their 2017 performance data by this date.
- **January 1, 2019:** The payment adjustments based on 2017 will go into effect by this date.

Please Note: In the 2017 performance period, Cost does not count toward an EC's final MIPS CPS and will not affect 2019 payments. In the 2018 performance period, CMS will begin using the Cost category to determine EC payment adjustment.

MIPS payment update schedule

When MACRA replaced the SGR and created MIPS, MACRA legislated the payment update schedule, adjustment factor, and additional incentive payments available to ECs. For the MIPS payment schedule set by MACRA, please see the table.

Additional information

Want more information? The Academy has created a wealth of resources, including specific reporting requirements for each of the performance score categories, available online through the Academy's MIPS page and MIPS brochure. The MIPS page is available here: **www.entnet.org/content/mips.** Access the AAO-HNS/F MIPS brochure here: **www.entnet.org/mips-reporting.** ■

MIPS PAYMENT SCHEDULE

Performance period	Payment period	Payment update	Adjustment factor	Additional incentive payment*
2017	2019	0.5%	± 4%	≤10%
2018	2020	0%	± 5%	≤10%
2019	2021	0%	± 7%	≤10%
2020 - 2023	2022 - 2025	0%	± 9%	≤10%
2024 +	2026 +	0.25%	± 9%	0

**For the first six years, MIPS ECs who are considered exceptional performers, as judged by CMS according to the CPS received for that performance period, may be eligible for an additional positive adjustment of up to 10 percent.*

FROM THE OREBM COMMITTEE SERIES

Publications that may change your practice

Vikas Mehta, MD, MPH, Jennifer J Shin, MD, SM, committee chair, and **Gregory W. Randolph, MD**

In this *Bulletin* series, the Outcomes Research Evidence-Based Medicine Committee (OREBM) shares highlights from recent key publications in otolaryngology-head and neck surgery. We offer concise summaries of significant findings that may alter current surgical practice.

Nikiforov YE, Seethala RR, Tallini G, et al. **Nomenclature revision for encapsulated follicular variant of papillary thyroid carcinoma: a paradigm shift to reduce overtreatment of indolent tumors.** *JAMA Oncol.* 2016 Aug 1;2(8):1023-1029.

Thyroid cancer incidence has been increasing mostly due to intensified surveillance and incidental detection of largely small and indolent cancers, which are almost exclusively papillary thyroid carcinomas (PTC). A common PTC subtype is the follicular variant of PTC, which can be encapsulated or infiltrative. The encapsulated follicular variant of PTC (EFVPTC) accounts for approximately 20 percent of all thyroid malignancies in the U.S. and has been shown to be non-aggressive and genetically distinct from invasive malignancies. However, these tumors are still often managed in a similar manner to the infiltrative variety, which results in possible "overtreatment" with increased morbidity and cost. This retrospective, multi-institutional study compared outcomes in 268 tumors divided into two cohorts: group one included 138 tumors with pathologic confirmation of non-invasive EFVPTC, who had not received radioactive iodine (RAI) with at least 10 years of follow-up and group two consisted of 130 EVPTCs with vascular and/or tumor capsule invasion and at least one year of follow-up. The goal was to establish diagnostic criteria for pathologists to more accurately identify EFVPTC, and to suggest a revision of the nomenclature to exclude the term "carcinoma" thereby curtailing some of the "overtreatment."

Twenty-four working group pathologists who were blinded to the diagnoses reviewed the slides from the tumors and provided their diagnoses based on criteria established by consensus. Additionally, molecular analyses were performed on 37 cases initially submitted for inclusion within group one. The diagnoses were tabulated and the findings were presented at the initiation of a series of teleconferences aimed at refining groups one and two and achieving consensus on the histopathologic diagnostic criteria. At a face-to-face conference, the findings of the study, together with related molecular and clinical outcome information were discussed, and a new nomenclature was established.

In group one, among 109 patients observed for 10 to 26 years, all were alive with no evidence of disease. Sixty-seven of these patients were treated with lobectomy alone, and none had received RAI. In group two, among 101 patients, 85 patients were treated with RAI. Patients were observed for one to 18 years, and 12 (12 percent) registered an adverse

“In adopting this terminology, patients with NIFTP could be spared the anxiety of a cancer diagnosis and hopefully be managed more conservatively, requiring only lobectomy in many instances without the need for adjuvant RAI.”

event, with five patients developing distant metastases (lung and/or bone).

The working group defined a non-invasive EFVPTC as having the following four characteristics: 1. main morphological features, i.e., the follicular growth pattern and nuclear features of PTC; 2. lack of invasion, which separates this tumor from invasive EFVPTC; 3. clonal origin determined by finding a driver mutation, which indicates that the lesion is biologically a neoplasm; and 4. very low risk of adverse outcome when the tumor is non-invasive. As a result, the term **“non-invasive follicular thyroid neoplasm with papillary-like nuclear features” (NIFTP)** was proposed and accepted by the group. In adopting this terminology, patients with NIFTP could be spared the anxiety of a cancer diagnosis and hopefully be managed more conservatively, requiring only lobectomy in many instances without the need for adjuvant RAI.

While the NIFTP nomenclature is nascent, numerous societal endorsements for this concept include the American Academy of Otolaryngology—Head Neck Surgery, the American Head and Neck Society, the Endocrine Society, British Association of Endocrine and Thyroid Surgeons, Japanese Thyroid Association, International Neural Monitoring Study Group, World Congress on Thyroid Cancer, Latin American Thyroid Association, Brazilian Society of Head and Neck Surgery, and the Brazilian Society of Endocrinology and Metabolism.

The study has limitations due to its retrospective nature. Additionally, similar to distinguishing a follicular adenoma from follicular carcinoma, diagnosis requires examination of the excised specimen given that the cytologic and molecular diagnostics of NIFTP remain currently limited. Thus, while a more limited surgery can be performed, the new nomenclature does not eliminate surgical management of these entities altogether. These issues will likely be addressed in further prospective studies, molecular diagnostics, guidelines, and cytologic classifications. Overall, authors estimate that the adoption of a new nomenclature would significantly reduce the patients' psychological burden, medical over treatment, and expense. ■

PATIENT EDUCATION AND SHARED DECISION-MAKING TOOLS

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BPPV

CERUMEN IMPACTION

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

www.entnet.org/CPG

CLINICAL PRACTICE GUIDELINE

Benign Paroxysmal Positional Vertigo (Update)

Adapted from the **March 2017** Supplement to ***Otolaryngology–Head and Neck Surgery***. Read the guideline at **otojournal.org**.

The primary purpose of the update to the 2008 *Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo* is to improve quality of care and outcomes for benign paroxysmal positional vertigo (BPPV) by improving the accurate and efficient diagnosis of BPPV, reducing the inappropriate use of vestibular suppressant medications, decreasing the inappropriate use of ancillary testing such as radiographic imaging, and increasing the use of appropriate therapeutic repositioning maneuvers.

The 2017 update was chaired by **Neil Bhattacharyya, MD**, with **Samuel P. Gubbels, MD**, serving as the assistant chair, and **Seth R. Schwartz, MD, MPH**, as the methodologist.

"The significant incidence of BPPV, its functional impact, and the wide diversity of diagnostic and therapeutic interventions for BPPV drove the need for an up-to-date practice guideline," said Dr. Bhattacharyya. "Our goal was to revise the 2008 guideline with an *a priori* determined and transparent process, reconsidering a more current evidence base while also factoring in BPPV treatments that result in improved quality of life for the patient."

Differences between the 2008 guideline and the 2017 update include:

- a consumer advocate added to the development group;
- new evidence from two clinical practice guidelines, 20 systematic reviews, and 27 randomized controlled trials;
- enhanced emphasis on patient education and shared decision-making;
- expanded action statement profiles to explicitly state quality improvement opportunities, confidence in the evidence, intentional vagueness, and difference of opinion;
- enhanced external review process to include public comment and journal peer review;
- a new algorithm to clarify decision making and action statement relationships; and
- new and expanded recommendations for the diagnosis and management of BPPV.

The update is endorsed by American Academy of Audiology (AAA), American Neurotology Society (ANS), American Otological Society (AOS), Society of Otorhinolaryngology Head-Neck Nurses (SOHN), American Academy of Emergency Medicine (AAEM), Vestibular Disorders Association (VEDA), American Physical Therapy Association (APTA), and The Triological Society. Additionally, the American Academy of Family Physicians (AAFP) and the American Academy of Neurology (AAN) gave an Affirmation of Value.

The full guideline, as well as other resources, are available at **http://www.entnet.org/BPPVcpg** as well as in *Otolaryngology–Head and Neck Surgery* as published at otojournal.org.

The guideline is intended for all clinicians who are likely to diagnose and manage patients with BPPV, and it applies to any setting in which BPPV would be identified, monitored, or managed.

The primary outcome considered in this guideline is the resolution of the symptoms associated with BPPV. Secondary outcomes considered include an increased rate of accurate diagnoses of BPPV, a more efficient return to regular activities and work, decreased use of inappropriate medications and unnecessary diagnostic tests, reduction in recurrence of BPPV, and reduction in adverse events associated with undiagnosed or untreated BPPV. Other outcomes considered include minimizing costs in the diagnosis and treatment of BPPV, minimizing potentially unnecessary return physician visits, and maximizing the health-related quality of life of individuals afflicted with BPPV.

GUIDELINE KEY ACTION STATEMENTS

1a DIAGNOSIS OF POSTERIOR SEMICIRCULAR CANAL BPPV

Clinicians **should** diagnose posterior semicircular canal BPPV when vertigo associated with torsional, up-beating nystagmus is provoked by the Dix-Hallpike maneuver, performed by bringing the patient from an upright to supine position with the head turned 45 degrees to one side and neck extended 20 degrees with the affected ear down. The maneuver should be repeated with the opposite ear down if the initial maneuver is negative.

1b DIAGNOSIS OF LATERAL (HORIZONTAL) SEMICIRCULAR CANAL BPPV

If the patient has a history compatible with BPPV and the Dix-Hallpike test exhibits horizontal or no nystagmus, the clinician **should** perform, or refer to a clinician who can perform, a supine roll test to assess for lateral semicircular canal BPPV.

2a DIFFERENTIAL DIAGNOSIS

Clinicians **should** differentiate, or refer to a clinician who can differentiate, BPPV from other causes of imbalance, dizziness, and vertigo.

2b MODIFYING FACTORS

Clinicians **should** assess patients with BPPV for factors that modify management including impaired mobility or balance, central nervous system disorders, a lack of home support, and/or increased risk for falling.

3a RADIOGRAPHIC TESTING

Clinicians **should not** obtain radiographic imaging in a patient who meets diagnostic criteria for BPPV in the absence of additional signs and/or symptoms inconsistent with BPPV that warrant imaging.

3b VESTIBULAR TESTING

Clinicians **should not** order vestibular testing in a patient who meets diagnostic criteria for BPPV in the absence of additional vestibular signs and/or symptoms inconsistent with BPPV that warrant testing.

4a REPOSITIONING PROCEDURES AS INITIAL THERAPY

Clinicians **should** treat, or refer to a clinician who can treat, patients with posterior canal BPPV with a canalith repositioning procedure.

4b POST-PROCEDURAL RESTRICTIONS

Clinicians **should not** recommend post procedural postural restrictions after canalith repositioning procedure for posteriorcanal BPPV.

4c OBSERVATION AS INITIAL THERAPY

Clinicians may offer observation with follow-up as initial management for patients with BPPV.

5 VESTIBULAR REHABILITATION

The clinician may offer vestibular rehabilitation in the treatment of BPPV.

6 MEDICAL THERAPY

Clinicians **should not** routinely treat BPPV with vestibular suppressant medications such as antihistamines and/or benzodiazepines.

7a OUTCOME ASSESSMENT

Clinicians **should** reassess patients within one month after an initial period of observation or treatment to document resolution or persistence of symptoms.

7b EVALUATION OF TREATMENT FAILURE

Clinicians **should** evaluate, or refer to a clinician who can evaluate, patients with persistent symptoms for unresolved BPPV and/or underlying peripheral vestibular or central nervous system disorders.

8 EDUCATION

Clinicians **should** educate patients regarding the impact of BPPV on their safety, the potential for disease recurrence, and the importance of follow-up. ■

Guideline authors

Neil Bhattacharyya, MD; Samuel P. Gubbels, MD; Seth R. Schwartz, MD, MPH; Jonathan A. Edlow, MD; Hussam El-Kashlan, MD; Terry Fife, MD; Janene M. Holmberg, PT, DPT, NCS; Kathryn Mahoney; Deena B. Hollingsworth, MSN, FNP-BC, CORLN; Richard Roberts, PhD; Michael D. Seidman, MD; Robert Wm. Prasaad Steiner, MD, PhD; Betty Tsai Do, MD; Courtney C. J. Voelker, MD, PhD; Richard W. Waguespack, MD; Maureen D. Corrigan

AAO-HNSF Guideline development process and the obligations associated with the guideline recommendations are documented in the *Clinical Practice Guideline Development Manual, Third Edition: a quality-driven approach for translating evidence into action.* (http://oto.sagepub.com/content/148/1_suppl/S1.long)

PATIENT INFORMATION

Frequently Asked Questions:

Benign Paroxysmal Positional Vertigo (BPPV)

QUESTION	ANSWER
What is BPPV?	Benign Paroxysmal Positional Vertigo (BPPV) is the most common inner ear problem and cause of vertigo, or false sense of spinning. BPPV is a specific diagnosis and each word describes the condition: **B**enign: *it is not life-threatening, even though the symptoms can be very intense and upsetting* **P**aroxysmal (par-ek-siz-muhl): *it comes in sudden, short spells* **P**ositional: *certain head positions or movements can trigger a spell* **V**ertigo: *feeling like you are spinning or the world around you is spinning*[1]
What causes BPPV?	There are crystals of calcium carbonate that are a normal part of our inner ear and help us with our balance and body motion. These tiny rocklike crystals or "otoconia" (oh-toe-cone-ee-uh) are settled in the center "pouch" of the inner ear. BPPV is caused by the crystals becoming "unglued" from their normal place. They begin to float around and/or get stuck on sensors in the wrong part or wrong canal of the inner ear. The most intense part of your BPPV symptoms have to do with how long it takes the crystals or sensor to settle after you move or change your head or body position. As the crystals move and settle, your brain is getting powerful (false) messages telling you that you are violently spinning when all you may have done is laid down or rolled over in bed.
What are the common symptoms and how can BPPV affect me?	Everyone will experience BPPV differently, but there are common symptoms. The most common symptoms are distinct triggered spells of vertigo or spinning sensations. You may experience nausea (sometimes vomiting) and/or a severe sense of disorientation in space. You may also feel unstable or like you are losing your balance. These symptoms will be intense for seconds to minutes. You can have lasting feelings of dizziness and instability, but at a lesser level, once the episode has passed. In some people, especially seniors, BPPV can appear as an isolated sense of instability brought on by position change like sitting up, looking up, bending over and reaching. BPPV does not cause constant severe dizziness and is usually triggered by movement. BPPV does not affect your hearing or cause you to faint. The natural course of BPPV is to become less severe over time. People will often report that their very first BPPV spinning episode was the worst and the following episodes were not as bad.

[1] Adapted from Woodhouse, S. "Benign Paroxysmal Positional Vertigo (BPPV)". (n.d., para. 1). Retrieved from https://vestibular.org/understanding-vestibular-disorders/types-vestibular-disorders/benign-paroxysmal-positional-vertigo

SOURCE: Bhattacharyya, NM, Gubbels, SP, Schwartz, SR, et al; Clinical Practice Guideline (Update): Benign Paroxysmal Positional Vertigo. *Otolaryngol Head Neck Surg.* In press.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

www.entnet.org

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, research, and lifelong learning. The organization's vision: "Empowering otolaryngology–head and neck surgeons to deliver the best patient care."

PATIENT INFORMATION

Frequently Asked Questions:

Benign Paroxysmal Positional Vertigo (BPPV)

QUESTION	ANSWER
How common is BPPV?	BPPV is very common. It is more common in older people. Many of us will experience it at some time in our lives.
What caused my BPPV?	Most cases of BPPV happen for no reason. It can sometimes be associated with trauma, migraine, other inner ear problems, diabetes, osteoporosis, and lying in bed for long periods of time (preferred sleep side, surgical procedures, illness).
How is BPPV diagnosed?	Normal medical imaging, such as scans and X-rays, or medical laboratory testing cannot confirm BPPV. Your health care provider or examiner will complete simple bedside testing to help to confirm your diagnosis. The bedside testing requires the examiner to move your head into a position that makes the crystals move and will make you dizzy. The testing may include hanging your head a little off the edge of the bed or rolling your head left and right while lying in bed. The examiner will be watching you for a certain eye movement to confirm your diagnosis. The most common tests are called the Dix-Hallpike test or supine roll test.
Can BPPV be treated?	Yes. Although medications are not used other than for relief of immediate distress, such as nausea, most BPPV cases can be corrected with bedside repositioning exercises that usually take only a few minutes to complete. They have high success rates (around 80%) although sometimes the treatment needs to be repeated a few times. These maneuvers are designed to guide the crystals back to their original location in your inner ear. They can be done at the same time the bedside testing for diagnosis is being performed. You might be sent to a health professional (medical provider, audiologist or therapist) who can perform these maneuvers, especially if you have any of the following: ■ severe disabling symptoms ■ you are a senior with history of past falls or fear of falling ■ you have difficulty moving around (such as joint stiffness especially in your neck and back and/or weakness). You can also be taught to perform these maneuvers by yourself with supervision which is called "self-repositioning."

SOURCE: Bhattacharyya, NM, Gubbels, SP, Schwartz, SR, et al; Clinical Practice Guideline (Update): Benign Paroxysmal Positional Vertigo. *Otolaryngol Head Neck Surg.* In press.

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Benign Paroxysmal Positional Vertigo (BPPV)

QUESTION	ANSWER
Is there any down side to BPPV repositioning treatments?	During the actual BPPV treatment there can be some brief distress from vertigo, nausea, and feelings of disorientation. Following the treatment, some people report their symptoms start to clear right away. Many times, others report that they have continuing motion sickness-type symptoms and mild instability. These symptoms can take a few hours or a few days to go away.
Can BPPV go away on its own?	There is evidence that if BPPV is left untreated, it can go away within weeks. However, remember that while the crystal is out of place, in addition to feeling sick and sensitive to motion, your unsteadiness can increase your risk for falling. You will need to take precautions not to fall. You are at a higher risk for injury if you are a senior or have another balance issue. Seniors are encouraged to seek professional help quickly to resolve symptoms.
How do I know my BPPV has gone away?	The strong spinning sensations that have been triggered by position changes should be greatly reduced if not completely gone.
How long will it take before I feel better?	You can still feel a little bit sensitive to movement even after successful treatments for BPPV. You can also feel unsteady at times. These mild symptoms can take a few days to a few weeks to slowly go away. You should follow up with your medical provider or physical therapist if your symptoms of dizziness or instability do not get better in a few days to a couple of weeks. Seniors with a history of falls or fear of falling may need further exercises or balance therapy to clear BPPV completely.
Is there anything I should or shouldn't do to help my BPPV?	Yes. Your balance will be "off" so you will need to take precautions that you don't fall. You will feel more sensitive to movement until the BPPV has been successfully treated and healed. After your symptoms are slowly going away, it is important to return to normal activities that you can do safely. Exposure to motion and movement will help to speed your healing.

SOURCE: Bhattacharyya, NM, Gubbels, SP, Schwartz, SR, et al; Clinical Practice Guideline (Update): Benign Paroxysmal Positional Vertigo. *Otolaryngol Head Neck Surg.* In press.

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PATIENT INFORMATION

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Benign Paroxysmal Positional Vertigo (BPPV)

QUESTION	ANSWER
Can BPPV come back and/or can I prevent it?	Unfortunately, BPPV is a condition that can sometimes return. Your risk for BPPV returning can shift from low risk (few experiences in your lifetime) to a higher risk which is often caused by some other factor such as trauma (physical injury), other inner ear or medical conditions, or aging. Medical research has not found any way to stop BPPV from coming back, but it can be treated with a high rate of success.
What happens if I still have symptoms following my initial treatments?	There are a number of reasons your initial treatment could have failed. 1. It is not uncommon to need more than one repositioning session to get the crystals back in their proper place. You may only need a few more treatments. 2. There are a number of different forms or types of BPPV which can require special treatment. The self-treatment is designed for the most common form of BPPV. There are a number of other treatments available which depend on the different types of BPPV. 3. BPPV can sometimes be in more than one canal and/or side at the same time. This would require multiple treatments to resolve. 4. If your initial tries at repositioning have failed, mainly if you have only tried self-repositioning, seek a health professional who specializes in BPPV. It can be difficult to complete correct positioning by yourself. A professional may be able to complete better positioning and/or use helpful equipment. 5. There can be some significant leftover dizziness even after the BPPV crystals have been correctly repositioned. This dizziness may require more time (few days to couple of weeks) or it may be appropriate for a different exercise/movement routine. It is VERY important to follow-up with your healthcare provider if you continue to have symptoms. You may be sent for further testing to confirm your diagnosis and/or discuss further treatment options.
Resources:	**AAO-HNS/F:** For more information on BPPV, visit: **www.entnet.org/BPPVCPG** **Vestibular Disorders Association (VEDA):** **INFO@vestibular.org** 5018 NE 15th Ave., Portland OR 97211 (800) 837-8428

SOURCE: Bhattacharyya, NM, Gubbels, SP, Schwartz, SR, et al; Clinical Practice Guideline (Update): Benign Paroxysmal Positional Vertigo. *Otolaryngol Head Neck Surg.* In press.

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OTO News

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

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Bassett Healthcare Network
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Otolaryngologist

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 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. Home to the National Baseball Hall of Fame and Museum, the Glimmerglass Opera Company, and the Fenimore Art Museum, the area also boasts many cultural and four season recreational advantages including theater, music, museums, golf, sailing, hiking, and skiing.

EEO Employer

For confidential consideration, please contact:
Debra Ferrari, Manager, Medical Staff Recruitment
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 web-site at www.bassettopportunities.org

ENT CENTER OF THE OZARKS

Premier Otolaryngology Opportunity in Amazing University City in Northwest Arkansas

The Ear, Nose, and Throat Center of the Ozarks is the premier Otolaryngology practice in what was voted the third best overall place to live in the U.S. by U.S. News and World Report in 2016. We are seeking a personable, motivated full time BC/BE Otolaryngologist with an interest in either Otology or in Head and Neck Oncology (with the capacity to do free flaps and endocrine surgery) to join our lucrative and progressive clinic. Our group has 4 pedigreed surgeons that are all fellowship trained and/or double or triple boarded, mid-level providers, and doctorate level audiologists. Our services include a busy endocrine surgery practice, multidisciplinary laryngology practice with speech pathology and video stroboscopy, vestibular lab, award-winning cosmetic surgery practice with separate clinic space and staff, advanced rhinology practice with in-office surgery capability, well-established allergy practice, busy and very productive hearing aid and audiology practice, and up to date, advanced equipment.

We are seeking candidates who have a subspecialty interest in either Otology or Neurotology, or in Head and Neck Surgical Oncology and Endocrine Surgery who also still want to utilize their general Otolaryngology skills.

Highlights:
- great, rapidly growing area with great schools, many outdoors and arts opportunities, low-malpractice claims rate, and a vibrant major university
- solid, pleasant, well-trained, honest partners with an excellent reputation in the regional communities and also amongst the Otolaryngologists in the state and who are in leadership positions locally, regionally, and nationally
- a competitive starting salary with full benefits package
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Contact: Current Curriculum Vitae (CV) should be sent to:
Hayley Warmack
Director of Marketing and Business Development
Hayley.ent@gmail.com

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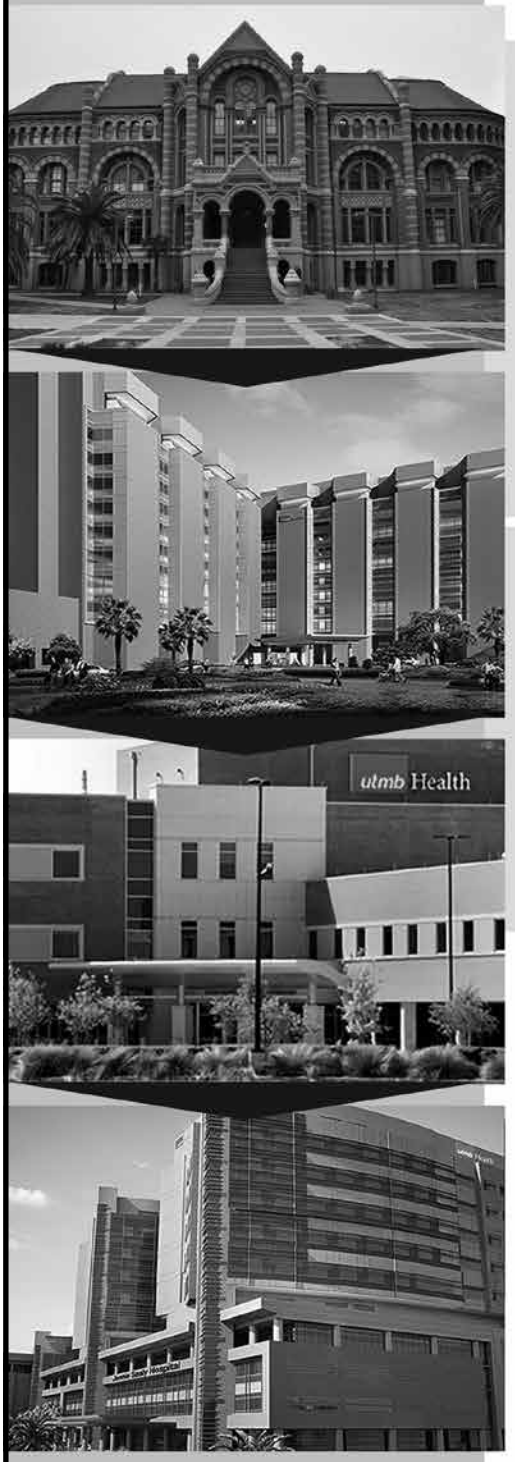

UTMB is an equal opportunity, affirmative action institution which proudly values diversity. Candidates of all backgrounds are encouraged to apply.

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting enthusiastic candidates for two full-time positions.

Otologist/Neurotologist
FULL-TIME BC/BE FELLOWSHIP TRAINED FACULTY

This position entails opportunities to participate in all aspects of clinical practice, as well as resident and medical student teaching. The department operates state of the art audiologic suites and a state of the art clinical vestibular laboratory established in collaboration with NASA to support our otologic/neurotologic experience. Clinical research is encouraged but not mandatory.

Head and Neck Surgical Oncologist/ Microvascular Reconstructive Surgeon
FULL-TIME BC/BE FELLOWSHIP TRAINED FACULTY

This position entails opportunities to participate in all aspects of clinical practice, as well as resident and medical student teaching. Clinical research is encouraged but not mandatory.

UTMB Health is undergoing rapid growth as exemplified by the building of two cutting-edge surgical hospitals and the acquisition of a third. With a light call schedule and generous benefits, this is an outstanding opportunity in one of the fastest growing geographic regions in the country.

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

ACADEMIC POSITION - PEDIATRIC OTOLARYNGOLOGY

Assistant or Associate Professor
Otolaryngology-Head and Neck Surgery
University of Washington and Seattle Children's Hospital
Seattle, Washington

The University of Washington Department of Otolaryngology-Head and Neck Surgery and the Division of Pediatric Otolaryngology at Seattle Children's Hospital are seeking a board certified/board eligible fellowship-trained pediatric otolaryngologist for a full-time academic position in the rank of Assistant Professor (0113) or Associate (0114) Professor without tenure. This position would be a multi-year appointment with a 12 month service period.

The Division's faculty members are committed to educating the next generation of physicians and academic otolaryngologists. As such they are active educators in the medical school, otolaryngology-head and neck surgery residency and pediatric otolaryngology fellowship training programs. This position will be based at Seattle Children's Hospital and affiliated ambulatory care center. Clinical responsibilities include patient care, call, and student, resident and fellow supervision and education. Priority will be given to candidates with funding for or a trajectory toward funded outcomes, clinical or translational research and expertise in airway management.

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

Send letter of interest and CV by May 1, 2017 to:
Kathleen Sie, MD
Division Pediatric Otolaryngology
Seattle Children's Hospital
4800 Sand Point Way NE, OA.9.220
Seattle, WA 98105-0371
Kathleen.sie@seattlechildrens.org

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Laryngologist (PIN 23075)
Neuro-otologist (PIN 23076)

The Department of Otolaryngology-Head and Neck Surgery, College of Medicine, University of Tennessee Health Science Center is seeking candidates for open-rank faculty positions at the Assistant/Associate Professor level to join a growing and dynamic department. Rank is commensurate with education, credentials, and experience. Qualified individuals must be Board Eligible/Certified and fellowship trained in Laryngology (PIN 23075) or fellowship trained in Neuro-otology (PIN 23076). Tenure status is negotiable. The department seeks individuals who are interested in becoming leaders in clinical and programmatic growth, education and research.

Letters of inquiry and CV should be sent to:

M. Boyd Gillespie, MD, MSc.,
Department of Otolaryngology-HNS,
U.T. Health Science Center,
910 Madison Avenue, Suite 408, Memphis, TN 38163
or email to: jkeys@uthsc.edu

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

Academic pediatric otolaryngology opportunity

Geisinger Medical Center's Department of Otolaryngology has an immediate opening for a fellowship-trained pediatric otolaryngologist.

Join nine otolaryngologists, including two fellowship-trained in pediatrics, providing all aspects of subspecialty care. Candidates should be BC/BE by the American Board of Otolaryngology, licensed or eligible to practice in Pennsylvania and have a commitment to academic otolaryngology, resident education and clinical research.

A competitive compensation and benefits package is offered for this position.

Interested applicants should send a cover letter and CV to:

Edward Wood, MD
Director, Pediatric Otolaryngology
wewood@geisinger.edu

cc: Sarah Lipka
Department of Professional Staffing
slipka1@geisinger.edu
570-271-5406

Geisinger

AA/EOE: disability/vet

geisinger.org/careers

AOC
HEAD & NECK SURGEONS

Private Practice Opportunity - General Otolaryngologist

Arizona Otolaryngology Consultants is one of the largest single specialty, physician-owned practices in the Valley, providing high quality medical care since 1997. Our group consists of multiple subspecialties, emphasizing all aspects of Otolaryngology/Head & Neck Surgery, including head & neck oncology, pediatric otolaryngology, laryngology, neurotology, hearing aid sales and CAT scanning. We offer patients ease of access at any of our 5 office locations and many surgery options as a result of over a dozen surgical affiliations.

Due to continued growth, we are looking to add a BC/BE General Otolaryngologist to our team of providers who offer a unique and collaborative approach to patient care.

Employment opportunities with AOC include:

- Excellent salary with partnership track
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- Malpractice insurance
- CME reimbursement

Interested candidates please submit your current CV and letter of interest to:

Alison Scott, Practice Manager – Alisons@aocphysicians.com
For more information about our practice, please visit
www. AOCPhysicians.com

Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. There are two Faculty opportunities at all academic ranks (Assistant/Associate Professor or Professor) available:

— **General Otolaryngology with an interest/experience or fellowship training in Laryngology**

Title, track, and salary are commensurate with experience.

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

To apply for a position, please visit the MU web site at
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The University of Missouri is an Equal Opportunity/Access/Affirmative Action/Pro Disabled & Veteran Employer.

UF UNIVERSITY of FLORIDA

University of Florida Pediatric & General Otolaryngology Positions

The Department of Otolaryngology at the University of Florida is seeking applicants who wish to pursue a career in Pediatric Otolaryngology. We are excited to announce 2 faculty positions: A Pediatric Otolaryngologist for our main campus in Gainesville, and either a Pediatric Otolaryngologist, or a General Otolaryngologist—with strong interest in Pediatric Otolaryngology—in Pensacola, Florida.

Gainesville: The division currently consists of 2 fellowship-trained Pediatric Otolaryngologists, within our growing department of 11 full-time University of Florida Faculty members.

The Division of Pediatric Otolaryngology is growing, and current practice locations include UF Health Shands Children's Hospital and the UF Health Children's Surgical Center. In addition, work has begun on the construction of a new, free-standing Otolaryngology clinic facility. The UF Health Shands Children's Hospital—recently ranked in 9 pediatric subspecialties in the 2016-2017 US News and World Report rankings—consists of 200+ inpatient beds, including a 24-bed PICU, 23-bed Pediatric Cardiac ICU, 68-bed NICU, and a Level I pediatric trauma center and Emergency Department.

A fellowship in Pediatric Otolaryngology is strongly encouraged. Applicants should also be board certified or board eligible and licensed (or eligible) to practice in Florida. Additionally, active involvement in both Otolaryngology resident and medical student education is expected.

Gainesville is a charming city and home to the University of Florida. The area is known for its natural beauty, with many springs, lakes and rivers. The mild climate encourages outdoor activities and residents enjoy swimming, boating, fishing, bicycling and camping. Culturally, the city is enriched by the influence of the university. The population of Gainesville is approximately 111,000 with a surrounding population of 250,000. We have a diverse culture, excellent public schools, low cost of living and no state income tax. For the past 8 years Gainesville has been voted among the Top 12 "Most Livable Cities in the Nation" by Money Magazine.

Pensacola: We are excited to announce an expanded partnership with The Studer Family Children's Hospital at Sacred Heart in Pensacola. We are seeking General Otolaryngologists with an interest in Pediatric Otolaryngology for Northwest Florida's only children's hospital.

Located in the Florida Panhandle—amidst the world's whitest sand beaches—Pensacola has been named in CNN/Money Magazine's "Best Cities to Live" and has been named "Boomtown" by Inc. Magazine. Pensacola offers beautiful homes to suit any budget, offers a cost of living that is well below the national average, along with excellent schools, no state income tax, and numerous outdoor activities. Here, you can live and practice where others only dream of living!

Candidates should have completed a fellowship in Pediatric Otolaryngology, or a General Otolaryngology residency from an ACGME accredited program, be board certified or board eligible, and licensed (or eligible) to practice in Florida. Interested candidates should send a letter of interest and CV to:

William O. Collins, M.D., FACS, FAAP
Associate Professor
Chief, Division of Pediatric Otolaryngology
William.collins@ent.ufl.edu

The University of Florida is an equal opportunity institution dedicated to building a broadly diverse and inclusive faculty and staff.

Children's National

Children's National Health System is seeking a qualified candidate for a non-tenured faculty position at the Assistant Professor level, the George Washington Univeristy Medical school, to function as a full time member in the Division of Otolaryngology. The position is effective July 2017.

Requirements for the position are candidates with an MD or equivalent degree, Board Certified or Board Eligible in Otolaryngology, and Fellowship trained in Pediatric Otolaryngology.

Responsibilities for the position include full time clinical and surgical care of patients, research to advance knowledge and understanding of pediatric otolaryngology, and education of medical students, residents and fellows.

Children's National Health System is an affirmative action and equal opportunity employer. We do not discriminate based on race, color, sex, religion, national origin, age, disability, marital status, ancestry, personal appearance, sexual orientation, family responsibility, matriculation, political, or any other unlawful basis. Interested candidates should send their curriculum vitae and letter of interest to:

Eric N. Baker, M.H.S.A.
Program Manager, Otolaryngology
Children's National Health System
111 Michigan Avenue, N.W.
Washington, D.C. 20010
202-476-8389

For complete details on this position and to apply online, please visit careers at: www.childrensnational.org and search by Requisition #160000FD

Northern Arizona Ear Nose & Throat PC

We are recruiting a second FT general/surgical otolaryngologist (BC/BE) for our highly successful ENT practice (one physician owner/founder) located in Flagstaff, Arizona.

Our practice is well established and expanding to better serve Flagstaff and surrounding communities.

Practice Highlights

- **Busy, ready-made practice with a strong referral base**
- **Work out of one hospital and one satellite clinic in Sedona, AZ**
- **Dedicated suite in our ASC**
- **Audiology on site**
- **1:5 call schedule for hospital (may change)**
- **EMR (Athena)**
- **Completive Salary and Benefits**
- **Flexible to offer tailored hours for balance of work and lifestyle**
- **Cohesive office staff dedicated to providing the best medical care**

Nestled at the base of the San Francisco Peaks, Flagstaff has the charm of a small town with the diversity and opportunities of a big city. It is a recreation destination for all seasons. The home of Northern Arizona University, Flagstaff is the hub of many of the state's natural attractions, including the Grand Canyon, Lake Powell, Snowbowl Ski Resort and Sedona, with an easy two hour drive to Phoenix.

Interested applicants should send a current CV to:

Northern Arizona Ear, Nose & Throat, PC
1300 Rim Drive, Suite B, Flagstaff, AZ 86001
928-606-2150
Fax: 928-556-0336 • flagstaffdowns@gmail.com • NAENT.COM

Washington University in St. Louis
School of Medicine

CHIEF, HEAD & NECK SURGERY

The Department of Otolaryngology-Head and Neck Surgery at Washington University School of Medicine invites applications for a full-time faculty position at the Associate Professor/Professor level in the Division of Head & Neck Surgery. We are seeking candidates with the vision and leadership abilities to serve the role of Division Chief, Head & Neck Surgery within the Department and to lead the institutions multidisciplinary cancer care effort in this discipline. This position includes an Endowed Chair and substantial support for building the basic and translational research efforts in head & neck cancer as a part of the extraordinary research environment at Washington University School of Medicine. Fellowship training or extensive experience in head & neck oncologic surgery and multidisciplinary cancer care is required. We encourage candidates with a strong research background and a commitment to education to apply. This position will include patient care responsibilities at Barnes-Jewish Hospital & the Siteman Cancer Center, an NCI Comprehensive Cancer Center & member of the National Comprehensive Cancer Network (NCCN). Candidates must be able to obtain a Missouri State license and must be board certified or eligible for certification. Interested applicants are invited to submit their CV on the WUSM website at: https://facultyopportunities.wustl.edu

Craig A. Buchman, MD, FACS
Lindburg Professor and Head
Department of Otolaryngology-Head & Neck Surgery
Washington University School of Medicine

Washington University in St. Louis is committed to the principles and practices of equal employment opportunity and affirmative action. It is the university's policy to recruit, hire, train, and promote persons in all job titles without regard to race, color, age, religion, gender, sexual orientation, gender identity or expression, national origin, veteran status, disability, or genetic information.

Barnes-Jewish Hospital BJC HealthCare | Washington University in St. Louis Physicians | Children's Hospital • St. Louis

Chester County Otolaryngology & Allergy Associates

SCENIC PHILADELPHIA SUBURBS

- Flourishing four physician Otolaryngology practice seeking an additional BC/BE physician.
- Located in beautiful Chester County, Pennsylvania's fastest growing county, with easy access to Philadelphia, New York City, Washington DC, mountains, and shoreline.
- Current services include audiology with hearing aid dispensing and balance testing, sinus surgery and allergy testing/immunotherapy, endocrine surgery, head and neck oncologic surgery, reconstruction of malignant cutaneous defects, and general pediatric and adult otolaryngology.
- Competitive salary, early partnership, health/dental insurance, 401k/Profit Sharing, paid CME and vacation.

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

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Offices conveniently located in Queens, Long Island, Brooklyn and The Bronx.

For more information contact Carlos Lopez at (516) 220-6448 or nyents@optonline.net

Pediatric Otolaryngology Faculty Positions

The Indiana University School of Medicine (IUSM) Department of Otolaryngology-Head & Neck Surgery in Indianapolis, Indiana is seeking full time BC/BE faculty physicians to join its comprehensive and growing department. Responsibilities include participation in an active pediatric otolaryngology practice, teaching residents and medical students, and participating in scholarly activities. Candidates must be fellowship-trained in all aspects of pediatric otolaryngology. Rank and salary will be commensurate with level of experience.

Riley Hospital for Children at IU Health

Riley Hospital for Children is a tertiary care teaching hospital located in downtown Indianapolis serving more than 300,000 children per year. Our practice includes the spectrum of pediatric otolaryngology including complex airway and sleep, head & neck masses/congenital malformations, hearing loss/otology, craniofacial, rhinology, laryngology/pediatric voice, speech, and vascular anomalies.

Riley Hospital for Children at IU Health North Hospital

IU Health North is a full service 189-bed hospital located 10 miles north of downtown Indianapolis. This state-of-the-art facility has dedicated pavilions for specialty surgery and an attached medical office building. Our practice focuses on general pediatric otolaryngology, including sleep disorders, airway disorders, rhinology and otology.

Please indicate position of interest, submit CV and arrange to have three letters of reference sent to:

Marion Everett Couch, MD PhD MBA FACS
Richard T. Miyamoto Professor and Chair
Department of Otolaryngology – Head & Neck Surgery
Indiana University School of Medicine

SCHOOL OF MEDICINE
INDIANA UNIVERSITY

Fesler Hall • 1130 W. Michigan St, Suite 400 • Indianapolis, IN 46202 • smaxwell@iupui.edu

Indiana University is an EEO/AA employer, M/F/D/V.

Excellent Otolaryngology Opportunity in the Midwest - Toledo, Ohio

ProMedica Physicians Ear, Nose & Throat, Toledo's premier ENT practice is seeking highly motivated, personable BC/BE Otolaryngologists to join their progressive and expanding practice. The practice consists of 5 ENT physicians, of which 3 are fellowship trained, offering patients the full spectrum of ENT services. The services include: allergy testing and treatment, and complete audiology and vestibular services including VNG, rotary chair, posturography, and cochlear implantation and mapping. In addition, a full time speech pathologist that offers videostroboscopy & voice analysis with speech therapy, dysphagia evaluation and treatment.

ENT Practice located in ProMedica Health and Wellness Center, a three-story, 230,000-square-foot center that brings a full-spectrum of care under one roof housing primary care and specialty physician offices; medical imaging, laboratory, behavioral health and wellness services; an endoscopy center; ProMedica Optical; ProMedica Pharmacy Counter; ProMedica Urgent Care; and a food pharmacy.

We are seeking candidates who excel at general ENT with advanced subspecialty interest and fellowship trained in:
• Neurotology / Otology • Head and Neck Surgical Oncology • Laryngology

Highlights:
- Opportunity to join a collegial, dynamic team of 5 Otolaryngologists
- "Built in" referral base and high volume
- Call shared equally among all members (currently 1:5)
- Trauma call is optional and paid separately
- Opportunity for teaching residents and medical students
- All members participate in weekly board meetings
- Full employment with ProMedica Physicians
- CME allowance plus vacation, holiday and sick time
- Perfect balance of work and lifestyle

For more information, contact:
Deanna Stocker
Physician Recruiter
deanna.stocker@promedica.org
419-824-7456

Employment with ProMedica Physicians includes:
- Competitive compensation and generous benefit package to include medical, dental, vision, life insurance, long & short-term disability, deferred retirement options and malpractice insurance
- Relocation paid up to $10K
- Being part of a diverse provider network that focuses on high-quality and patient-centered care.

ProMedica Physicians is a multi-specialty physician network of more than 900 physicians and midlevel providers throughout northwest Ohio and southeast Michigan. The ProMedica Physician professional team handles every aspect of practice management including billing, coding, compliance, human resources, legal issues and marketing to name a few. For more information, please visit www.promedica.org/doctors.

PROMEDICA | Your health. Our mission.

Excellent Neurotologist Opportunity in the Midwest - Toledo, Ohio

ProMedica Physicians Ear, Nose and Throat is seeking a full time BE / BC Neurotology fellowship-trained individual to join a five-physician ENT group based in Toledo, Ohio. Three partners within the group are fellowship-trained subspecialists.

Highlights:
- Oversee an existing, comprehensive "turn-key" neurotology practice
- Complete audiology and vestibular services including VNG, rotary chair, posturography cochlear implantation and mapping
- Collaborative, multidisciplinary culture
- ProMedica ensures you have the means to deliver exceptional personalized care to your patients
- Mix of general ENT and neurotology
- Group meets weekly for board meeting
- Strong referral base from within group and the surrounding community
- Employment with ProMedica Physicians Includes:
- Competitive compensation and generous benefit package to include medical, dental, vision, life insurance, long & short term disability, deferred retirement options and malpractice insurance
- Relocation paid up to 10k
- Teaching and research opportunities
- Being a part of diverse provider network that focuses on high-quality and patient-centered care
- Toledo, population 300,000, is the 4th largest city in Ohio offering attributes of a large city while maintaining the atmosphere and charm of a small town. The Toledo Zoo is #1 in the US. The area offers an extensive Metro park system, Museum of Art, and excellent institutions of higher education. Toledo is home to a minor league baseball team, and hockey team. Located within 1 hour access of other professional sports teams.
- **Attractive sign on bonus**

For more information, contact:
Deanna Stocker
Physician Recruiter
deanna.stocker@promedica.org
419-824-7456

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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 recently launched the Robotics Institute and added a Vascular Malformations Program. Additionally, our experts are on the faculty of the Icahn School of Medicine at Mount Sinai, ranked among the nation's top medical schools by *U.S. News & World Report*, and the Head and Neck Cancer Research Program is the foremost international resource for tumor dormancy research.

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

Mount Sinai *New York*

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