

# bulletin

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

OCTOBER 2017



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# bulletin

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\*Rhodus, N.L.: The Effectiveness of Artificial Salivas in Relieving Xerostomia as Assessed by Mucoprotective Relativity., J Dent Res 70:407, 1991. Abstract 1133.

# Re-imagine the future

I am confident in assuring you, every member of this esteemed Academy, that the *future of otolaryngology is bright and strong!*

My goal is to focus activities and initiatives within the strategic plan to make the practice of otolaryngology less complicated, more fulfilling, and more rewarding to continuously strengthen the joy from our collective ability to provide the best otolaryngology care to our patients.

Like most things in life, relationships and people (members and patients) are central to the success and meaningful outcome of any worthwhile endeavor. Just look around at your own activities and it is the strength, interconnectedness, trust, and ability to work together that yields the most meaningful results. The Academy is no different.

I am enormously proud and immensely humbled to assume the role of president of the American Academy of Otolaryngology—Head and Neck Surgery. I would like to thank Past-President **Gregory W. Randolph, MD**, and **James C. Denny III, MD, EVP/CEO**, for their tremendous mentorship, support, and leadership.

I share with you my vision and goals for the year ahead.

■ **Strengthen member relationship** and experience through transparent communication, collaboration, and organizational and fiscal responsibility to deliver on the AAO-HNS/F promises. Together, with our enormously talented and dedicated Academy staff, we will strengthen member satisfaction working with you at every level through all venues with diverse input, participation, and representation.

■ Ensure **specialty unity** is fundamentally important to the success of our future. Nurturing subspecialty society relationships with shared vision and goals, while collaborating with the American College of Surgeons (ACS), American Board of Otolaryngology (ABOto), and other key stakeholders in ongoing coalition-building efforts is “table stakes” moving forward. When we speak with one voice as a specialty and in the house of medicine, we have an opportunity to affect the discourse on healthcare reform, to optimize quality, access, and affordability of patient-centered care for all.

■ Adapt **strategic planning** at the leadership retreat in December to align our goals and tactics to the contemporary changes affecting our specialty, prioritizing high-quality activities, with ongoing opportunities to improve organizational performance,

while leveraging relationships, locally and globally.

■ Facilitate **data** liberation by leveraging Reg-ent<sup>SM</sup>, the AAO-HNS Qualified Clinical Data Registry (QCDR). In my opinion, it is the “great leveler.” It offers every otolaryngologist, in every practice setting, the ability to more easily comply with burdensome regulatory and reporting requirements for MACRA and MIPS, providing data capture, processing, and retrieval across the care continuum. You now can better demonstrate your quality and value to patients, regulators, payers, and others.

■ **Support wellness** and future practice in otolaryngology. These are transformational issues requiring introspective review and analysis to ensure that you, our members, remain healthy, resilient, and resourceful in delivering care in this rapidly changing, complex healthcare environment.

Burnout affects the whole profession. It is imperative and incumbent on the Academy to provide the tools and resources to ensure member wellness, while critically evaluating and adapting to expected changes in otolaryngology practice.

Workforce issues will require special attention: The roles of the generalist and specialist, education, to making relevant changes.

Challenge the assumption that **independent otolaryngology** practice is no longer viable. As a private practice Academy president, in a 10-physician, five-physician assistant practice, I assert that the future is positive, especially in an era of “site-neutrality” with respect to Medicare reimbursement for outpatient services provided in off-campus hospital outpatient settings. The financial motivation for hospital and other integrated medical systems to purchase private practices is declining and physician satisfaction in these models is deteriorating. More than 50 percent of practicing otolaryngologists are still in private practice settings.

Inspired leadership at all levels in the Academy, built on mutual respect, trust, shared aspirations, and goals, will allow us to further grow as a high-achieving culture and to function as a high-performance organization yielding astonishing results. Your buy-in and participation is crucial to our success.

Albert Einstein once said: “Logic will get you from A to Z. Imagination will get you everywhere.”

Join with us in this exciting challenge as we re-imagine the future of Otolaryngology—Head and Neck Surgery! ■



**Gavin Setzen, MD**  
AAO-HNS/F President

“I am enormously proud and immensely humbled to assume the role of president of the American Academy of Otolaryngology—Head and Neck Surgery.

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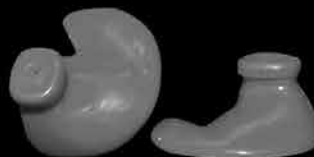


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# Shifting the healthcare debate

As the political season here in Washington, DC, winds down, it looks more and more like there will be no significant federal legislation advanced this year that might put us on the road to viable system reforms that will facilitate affordable access to care for our citizens at a price that will not bankrupt the country. Partisanship has dominated the healthcare reform debate or, as some might say, lack of debate for too long in the United States.

There has been tremendous energy and resources allocated to discussions that, even if successful, would not sufficiently alter the spending curve that threatens to approach 25 percent of the GDP by 2030. To me, perhaps the most important question that needs to be answered is, how do we shift the debate to include the “untouchables” that have the power to derail comprehensive reform by their exclusion?

The transition to “quality care” is admirable and should be embraced, not as the solution to runaway costs, but on an ethical and professional basis because it is the “right thing to do” for the populace of our country. Seeking “value” is also desirable, but in the context of current discussion, will not produce the savings necessary to achieve what would be the most desirable goal, affordable healthcare services for all.

Who are the “untouchables”? How did they evolve? Why are they “untouchable,” and how can we change that and bring everyone to the table with willingness to work for the good of the whole? As the healthcare delivery system has evolved into a multi-trillion dollar behemoth, we are now reaching the “too big to fail” label that was attached to the financial industry in recent years.

The insatiable appetite for “more” reminds me of Audrey II in “The Little Shop of Horrors” film and its the repeated request “Feed me, Seymour.” What began as a universally lauded goal to improve the health of the nation by increasing access and affordability and, most importantly, advancing the science of medicine in healthcare delivery has spun out of control, driven in part by the huge sums of money being pumped into the system paired with American’s penchant for consumption and excess as promoted in our current system driven by

ultra-capitalism. Capitalistic tenets including “maximize the profit,” “what the market will bear,” and “technology will lower the cost” have not proven successful to date.

Prior attempts to improve and expand the delivery system itself, while bringing costs more in line with the rest of the industrialized world, have been disappointing to say the least. Projected cost savings have not materialized and, in fact, quite the opposite is happening. Access for the middle class, employed patients has decreased with many foregoing care because of the unsupportable out-of-pocket expenses they now face. There is considerable concern that even if all of the quality and payment programs currently in use or under consideration were successful, they would not significantly alter the projected spending curve to a point that is truly affordable for this nation.

To shift the debate away from the current “finger in the dike” approach will require a philosophical change in the way we deal with healthcare delivery as a country and the willingness to participate in compromise by the group of 11 “untouchables.” Absent such a change we may well be looking at strict price controls or regulation like that seen in public utilities.

In my mind, the major players controlling the system and debate (in alphabetical order) are: ancillary service providers, attorneys, Congress, consultants, hospital systems, the insurance industry, medical device and instrument companies, Pharma, physicians, the public, and regulators at all levels. Each of these groups either has a significant stake or exists to provide the best patient care to our population. Each of these groups has developed expertise in advocating for their contribution to fulfilling the goal of maximizing patient care. Unfortunately, under the fragmented system that exists today, this has only served to inflate costs. The utopian next step would involve a collaborative gathering of these stakeholders that would all be committed to defining the reality of the situation, defragmenting the system, compromising with a willingness to alter their existing model to work for the good of the whole. Initial discussions such as these have the potential to start us on the road to give our citizens what they deserve. Next month, I will continue this discussion with an in-depth look at each of the “untouchables” and specific areas in which each group can contribute. ■



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

“To shift the debate away from the current “finger in the dike” approach will require a philosophical change in the way we deal with healthcare delivery as a country and the willingness to participate in compromise by the group of 11 “untouchables.”

”



BOARD OF GOVERNORS

# Otolaryngology: Are we a unified specialty?

■ Sanjay R. Parikh, MD  
BOG Chair

At our recent Washington state society meeting, I bumped into a friend who works as a solo private practitioner in the community. She feels burned out by her administrative burdens and worries that her practice is not sustainable. She also fears that solo general practice is dying due to trends toward subspecialization and practice mergers. She made some good points: Most new resident graduates are pursuing fellowship training, and many other seasoned otolaryngologists are joining hospital-based practices. She asked me if our once broad specialty is unified or if we are moving toward division by subspecialty interest? Great question.

Starting this month, I am honored to serve as the 35th chair of our Academy's Board of Governors (BOG). The BOG was established as a forum for Academy members and society leaders to share practice challenges and help steer the Academy toward prioritizing issues which best support its members. For this upcoming year, I'll ask our BOG committees to work on three goals:

■ **Member Unity:** This past year, the BOG Governance and Society Engagement (GSE) Committee did an amazing job of initiating the 'State OTO Society Roundtable' near our Academy headquarters in Alexandria, VA. It was extremely well-attended by the majority of state society delegates just prior to our Academy's annual Leadership Forum & BOG Spring Meeting. This year, our GSE Committee will transition this roundtable to an annual forum for understanding and unifying the voices of our membership, regardless of specialty interest, across all states.



■ **Member Burnout:** The BOG Legislative Affairs Committee works on your behalf to advise our Academy's federal and state advocacy teams on current issues. This year, our Legislative Affairs Committee will focus on federal and state advocacy that quantifies and reduces the administrative and regulatory burden on all otolaryngologists regardless of practice pattern or subspecialty interest.

■ **Member Diversity:** The BOG Socioeconomic and Grassroots (SEGR) Committee has held steadfast in its core mission of understanding member practice challenges and lobbying for improvement. This year, this committee will be partnering with our Academy's Young Physicians Section, Section for Residents and Fellows-in-Training, Women in Otolaryngology Section, and Diversity and Inclusion Committee to build objectives and content as it relates to promoting an understanding of diversity within our Academy. I personally believe the face of otolaryngology has changed, and we must promote leadership and direction within the Academy that supports all of our members.

I look forward to the next time I see my friend at our state society meeting. I will tell her that the Academy and the BOG are listening to her concerns, that we are unified in our mission to support her practice and her patients, and that we want to engage her voice in an effort to produce change. Otolaryngology may be the best specialty in medicine. I believe this as I look forward to waking up and caring for my patients every day. The BOG exists to unify, support, and engage otolaryngologists so they may share this sentiment. ■

## 2018 Call for Science

Want to be a part of the 2018 Annual Meeting & OTO Experience?

**New this year!** There will be one timeframe to submit Instruction Course, International Symposium, Masters of Surgery Video Presentations, Miniseminar, and Scientific Oral/Poster Abstracts.

**Mark Your Calendars!** The submission site will open **Monday, November 20, 2017**, and close at **11:59 pm ET, Wednesday, January 17, 2018**. Please contact Programs at [programs@entnet.org](mailto:programs@entnet.org) for more information. ■

## Call for 2018 AAO-HNS candidates

The Nominating Committee of the Academy is calling for recommendations of individuals to be considered for an AAO-HNS elective office. Academy member(s) must be in good standing and recommend having held membership the last three consecutive years, have proven leadership qualities, be active in the Academy, be familiar with the strategic direction of the Academy, and be able to dedicate the necessary time to serve.

Please complete the application packet of materials and submit to any member of the Nominating Committee requesting he/she support your nomination for elected office. For more information and the application packet, visit <http://www.entnet.org/content/annual-election>.

**Application deadline is December 4, 2017. (No extensions permitted.) ■**



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## CALL FOR SCIENCE 2018 DEADLINES

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Contact [programs@entnet.org](mailto:programs@entnet.org) for more information

AMA HOUSE OF DELEGATES

# Issues impacting otolaryngology

■ **Michael S. Goldrich, MD**, Chair, AAO-HNS  
Delegation to the AMA House of Delegates

The American Medical Association (AMA) held its 2017 Annual House of Delegates (HOD) meeting June 10-14, in Chicago, IL. Several otolaryngologists represented the Academy: I currently serve as delegation chair; **Robert Puchalski, MD**, delegate and otolaryngology section council chair; **Douglas R. Myers, MD**, delegate; **Craig S. Derkay, MD**, alternate delegate; and **James C. Denny III, MD**, Academy EVP/CEO, alternate delegate. Here is a summary of a few of the hundreds of considered reports and resolutions that are most relevant to our specialty.

## Interpreter services

Recognizing the inequity of physicians being mandated to absorb the cost of interpreter services (both for spoken language and deaf interpreters), the AMA passed a resolution to advocate for payers, rather than physicians or their patients, being responsible for the cost of this ADA-required service. The resolution reads:

*That the AMA advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.*

This focus on Medicaid adds to existing AMA policy advocating for such relief from all payers. It also advocates for direct payment to interpreters rather than reimbursement to physicians for outlay.

## Maintenance of Certification

In many specialties across the House of Medicine, there has been severe dissatisfaction with the current Maintenance of Certification (MOC) process, especially in regard to relevant

educational opportunity and the “high stakes” examinations. Many certifying boards have been re-examining the content and parameters of the MOC process.

The HOD passed a resolution recognizing that lifelong learning is best achieved by ongoing participation in a program of high quality continuing medical education appropriate to that physician’s medical practice as determined by the relevant specialty society. It is anticipated that in every specialty, there will be ongoing robust dialogue with our specialty boards to improve the quality of this lifelong learning.

## Concurrent surgery

In recent years, there has been media interest and some public concern regarding surgeons



performing concurrent or overlapping surgery. In our specialty, there is a long history of overlapping procedures in some areas of surgical care. A resolution was discussed at the meeting to develop evidenced-based policy. In coordination with the American College of Surgeons (ACS) and other surgical specialties, the AAO-HNS delegation supported a planned dialogue among relevant national specialty societies on the issues inherent in these procedures.

The next meeting of the AMA HOD will be November 11-14, 2017, in Honolulu, HI. If you have questions regarding this report and other AMA HOD activities, please contact [govtaffairs@entnet.org](mailto:govtaffairs@entnet.org). ■

## Proposed rule for MPFS payments

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) posted the proposed rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2018. In addition to payment and policy updates, the MPFS addresses a number of issues affecting otolaryngologist – head and neck surgeons. In the rule, CMS proposes values for the newly developed Endoscopic Sinus Surgery (ESS) and sinus ostial dilation (e.g., balloons) codes developed in conjunction with the American Rhinologic Society (ARS) and the American Academy of Otolaryngic Allergy (AAOA).

CMS also proposes values for a number of other codes, discusses possible

revisions to E/M guidelines, outlines provisions for Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging starting in 2019, aligns the Physician Quality Reporting System (PQRS) and Value-based Payment Modifier (VBM) programs with Merit-based Payment System (MIPS) reporting criteria, and proposes new modifiers for patient relationship categories required under MIPS.

The Academy submitted comments to CMS on the proposed rule on September 1, 2017, and is available at <http://www.entnet.org/content/regulatory-advocacy>. Watch for the November *Bulletin* for a deeper explanation of what you need to know about proposals in the MPFS and how the Academy is advocating on your behalf. ■

## ***The first and only combination ear drop for AOMT in single-use vials<sup>1</sup>***

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#### **Contraindications**

OTOVEL is contraindicated in:

- Patients with known hypersensitivity to fluocinolone acetonide or other corticosteroids, ciprofloxacin or other quinolones, or to any other component of OTOVEL.
- Viral infections of the external ear canal, including varicella and herpes simplex infections and fungal otic infections.

The following Warnings and Precautions have been associated with OTOVEL: Hypersensitivity reactions, potential for microbial overgrowth with prolonged use, and continued or recurrent otorrhea.

The most common adverse reactions are otorrhea, excessive granulation tissue, ear infection, ear pruritus, tympanic membrane disorder, auricular swelling, and balance disorder.

**For additional Important Safety Information, please see Brief Summary of Prescribing Information on adjacent page and full Prescribing Information available at [www.otovel.com](http://www.otovel.com).**

**References:** 1. US Food and Drug Administration. Orange Book: Approved drug products with therapeutic equivalence evaluations. <https://www.accessdata.fda.gov/scripts/cder/ob/>. Accessed February 1, 2017. 2. Otovel [package insert]. Atlanta, GA: Arbor Pharmaceuticals, LLC.

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## OTOVEL® (ciprofloxacin and fluocinolone acetonide) otic solution

### Brief Summary of Prescribing Information

#### 1 INDICATIONS AND USAGE

OTOVEL is indicated for the treatment of acute otitis media with tympanostomy tubes (AOMT) in pediatric patients (aged 6 months and older) due to *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *Pseudomonas aeruginosa*.

#### 2 DOSAGE AND ADMINISTRATION

- OTOVEL is for otic use only. It is not for ophthalmic use, or for injection.

The recommended dosage regimen is as follows:

- Instill the contents of one single-dose vial 0.25 mL into the affected ear canal twice daily (approximately every 12 hours) for 7 days. Use this dosing for patients aged 6 months of age and older.
- Warm the solution by holding the vial in the hand for 1 to 2 minutes. This is to avoid dizziness, which may result from the instillation of a cold solution into the ear canal.
- The patient should lie with the affected ear upward, and then instill the medication.
- Pump the tragus 4 times by pushing inward to facilitate penetration of the medication into the middle ear.
- Maintain this position for 1 minute. Repeat, if necessary, for the opposite ear [see *Instructions for Use*].

#### 3 DOSAGE FORMS AND STRENGTHS

Otic Solution: Each single-dose vial of OTOVEL (ciprofloxacin 0.3 % and fluocinolone acetonide 0.025 %) delivers 0.25 mL of solution equivalent to ciprofloxacin 0.75 mg and fluocinolone acetonide 0.0625 mg.

#### 4 CONTRAINDICATIONS

OTOVEL is contraindicated in:

- Patients with known hypersensitivity to fluocinolone acetonide or other corticosteroids, ciprofloxacin or other quinolones, or to any other components of OTOVEL.
- Viral infections of the external ear canal, including varicella and herpes simplex infections and fungal otic infections.

#### 5 WARNINGS AND PRECAUTIONS

##### 5.1 Hypersensitivity Reactions

OTOVEL should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Some reactions were accompanied by cardiovascular collapse, loss of consciousness, angioedema (including laryngeal, pharyngeal or facial edema), airway obstruction, dyspnea, urticaria and itching. Serious acute hypersensitivity reactions may require immediate emergency treatment.

##### 5.2 Potential for Microbial Overgrowth with Prolonged Use

Prolonged use of OTOVEL may result in overgrowth of non-susceptible bacteria and fungi. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. If such infections occur, discontinue use and institute alternative therapy.

##### 5.3 Continued or Recurrent Otorrhea

If otorrhea persists after a full course of therapy, or if two or more episodes of otorrhea occur within 6 months, further evaluation is recommended to exclude an underlying condition such as cholesteatoma, foreign body, or a tumor.

#### 6 ADVERSE REACTIONS

The following serious adverse reactions are described elsewhere in the labeling: Hypersensitivity Reactions [see *Warnings and Precautions* (5.1)]

##### 6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In clinical trials, 224 patients with AOMT were treated with OTOVEL for a median duration of 7 days. All the patients received at least one dose of OTOVEL. There were 220 patients who received at least one dose of ciprofloxacin (CIPRO) and 213 patients received at least one dose of fluocinolone acetonide (FLUO). The most common adverse reactions that occurred in 1 or more patients are as follows:

**Table 1: Selected Adverse Reactions that Occurred in 1 or more Patients in the OTOVEL Group**

Adverse Reactions <sup>1</sup>	Number (%) of Patients		
	OTOVEL N=224	CIPRO N=220	FLUO N=213
Otorrhea	12 (5.4%)	9 (4.1%)	12 (5.6%)
Excessive granulation tissue	3 (1.3%)	0 (0.0%)	2 (0.9%)
Ear infection	2 (0.9%)	3 (1.4%)	1 (0.5%)
Ear pruritus	2 (0.9%)	1 (0.5%)	1 (0.5%)
Tympanic membrane disorder	2 (0.9%)	0 (0.0%)	0 (0.0%)
Auricular swelling	1 (0.4%)	1 (0.5%)	0 (0.0%)
Balance disorder	1 (0.4%)	0 (0.0%)	0 (0.0%)

<sup>1</sup> Selected adverse reactions that occurred in ≥ 1 patient in the OTOVEL group derived from all reported adverse events that could be related to the study drug or the drug class.

#### 6.2 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of ciprofloxacin and fluocinolone acetonide otic solution, 0.3% / 0.025% outside the US. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

- Immune system disorders: allergic reaction.
- Infections and infestations: candidiasis.
- Nervous system disorders: dysgeusia, paresthesia (tingling in ears), dizziness, headache.
- Ear and labyrinth disorders: ear discomfort, hypoacusis, tinnitus, ear congestion.
- Vascular disorders: flushing.
- Skin and subcutaneous tissue disorders: skin exfoliation.
- Injury, poisoning and procedural complications: device occlusion (tympanostomy tube obstruction).

#### 8 USE IN SPECIFIC POPULATIONS

##### 8.1 Pregnancy

###### Risk Summary

OTOVEL is negligibly absorbed following otic administration and maternal use is not expected to result in fetal exposure to ciprofloxacin and fluocinolone acetonide (12.3)].

##### 8.2 Lactation

###### Risk Summary

OTOVEL is negligibly absorbed by the mother following otic administration and breastfeeding is not expected to result in exposure of the infant to ciprofloxacin and fluocinolone acetonide.

##### 8.4 Pediatric Use

OTOVEL has been studied in patients as young as 6 months in adequate and well-controlled clinical trials. No major differences in safety and effectiveness have been observed between adult and pediatric patients.

##### 8.5 Geriatric Use

Clinical studies of OTOVEL did not include sufficient numbers of subjects aged 65 years and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients.

#### 10 OVERDOSAGE

Due to the characteristics of this preparation, no toxic effects are to be expected with an otic overdose of OTOVEL.

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For more detailed information, see the full prescribing information for Otovel at [www.otovel.com](http://www.otovel.com) or contact Arbor Pharmaceuticals, LLC at 1-866-516-4950.



# The benefits of participating in the Reg-ent<sup>SM</sup> registry

Reg-ent participation: the Value 4U and for the specialty

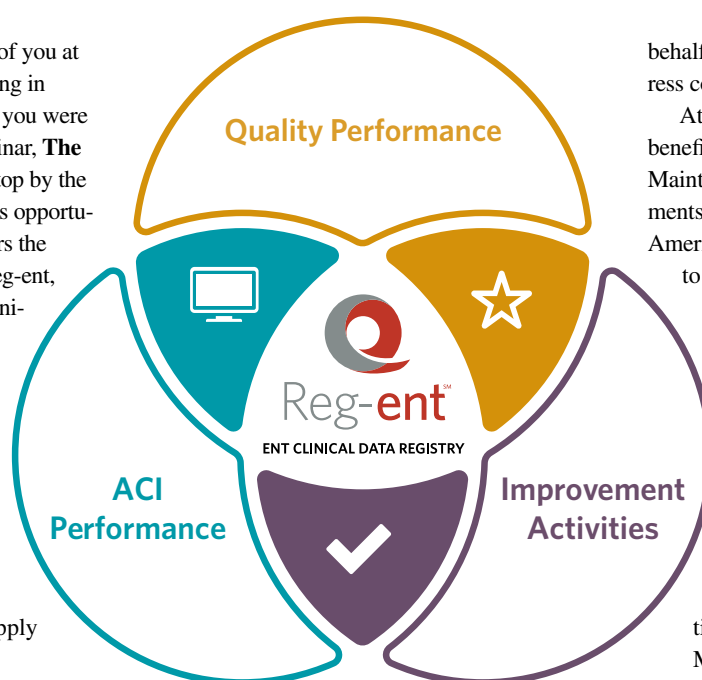
We enjoyed seeing so many of you at last month's Annual Meeting in Chicago, IL. We hope that you were able to attend the Reg-ent Miniseminar, **The Evolution of Measurement**, and stop by the Reg-ent booth. We'd like to take this opportunity to share with all of our members the many benefits of participation in Reg-ent, the Foundation's otolaryngology clinical data registry.

The benefits of participation in the registry are numerous—some are available now, others are in development for the future. Whether you are a solo practitioner, a large group private practice, or an academic medical center, there are many benefits to participating in the registry that apply directly to you.

Reg-ent was established by the Foundation to be the first repository of otolaryngology-specific data. This collective data will be used to guide the best ENT care.

The initial phase of Reg-ent was establishing the quality performance reporting functionality. Having received CMS designations as both a Qualified Registry (QR) and Qualified Clinical Data Registry (QCDR) in the registry's inaugural year, Reg-ent was able to successfully report PQRS 2016 data. The Reg-ent registry again received QR and QCDR designations from CMS in 2017, which allows members to report MIPS 2017 through Reg-ent. For 2017, Reg-ent supports not only the Quality Performance category reporting, but also the Advancing Care Information (ACI) and Improvement Activities (IA) reporting categories for MIPS 2017.

While the registry's primary data repository is built from the electronic integration of data



from our members' EHRs, the Foundation recognizes that many of our members in need of a MIPS-reporting solution are paper-based practices. Therefore, Reg-ent made a web entry tool available to our members who signed contracts by October 3, 2017. This web entry tool is also available to Reg-ent participants with EHRs from vendors that have yet to provide sufficient, reliable data electronically to the registry, or in some cases, provided no data at all.

To support the growth of the registry and to support our members at the practice level, the Foundation and the Reg-ent team continue to work with EHR vendors to improve the quality of the data provided to the registry—or in the cases where no data has been shared to date, encourage them to do so. FIGmd, Reg-ent's registry vendor partner, is also working globally with these same EHR vendors on

behalf of the registries FIGmd powers. Progress continues to be made.

At the individual provider level, another benefit of Reg-ent participation is meeting Maintenance of Certification (MOC) requirements. The AAO-HNSF is working with the American Board of Otolaryngology (ABOto) to have Reg-ent participation assist members with meeting MOC. We look forward to having updates on these capabilities soon.

It takes time to grow a registry in terms of participants and collected data. The Foundation intentionally planned the registry to be rolled out in a phased manner, with some functionality and benefits available immediately and other functionality developing over time.

MIPS reporting and MOC are important functionalities of the registry, necessary for many of our members, which is why reporting comprises the first phases. However, Reg-ent is more than a reporting tool. It is and will continue to become a national repository of otolaryngology-specific data that will assist in quality measures development, testing, and validation, leading to more relevant and meaningful measures.

As the registry collects data from our members across the country, Reg-ent's otolaryngology data will grow and represent an accurate and reliable resource for research purposes. The potential to use the data to make improvements to the care and outcomes of patients is infinite. The data repository can be used for quality improvement at the provider and practice levels as well as to support discussions with private and public payers regarding quality of care provided.

The power of the registry is in the data it collects and stores—data from our members

## ■ at the forefront

and their practices. As practicing otolaryngologists-head and neck surgeons, each of our members has data that is needed to develop the database that will support the improvements in otolaryngology care as defined by the specialty. Building the data repository depends on participation from our members. That means you! We need our members to invest in the future of the Reg-ent registry and the specialty now.

To learn more about Reg-ent and to join, please visit [www.Reg-ent.org](http://www.Reg-ent.org). If you have questions regarding Reg-ent participation, you can email the Reg-ent team at [Reg-ent@entnet.org](mailto:Reg-ent@entnet.org). ■

### Why your participation in Reg-ent<sup>SM</sup> matters

I am passionate about Reg-ent because it is one of the most important quality initiatives launched by the Foundation to date. It is the first national clinical data repository for otolaryngology head and neck data. I would like to see every member involved and part of the Reg-ent registry.

It is the single best investment for our future and the future of the specialty as a whole. Reg-ent serves to define quality for the specialty. We are:

- Creating a data repository for research as the volume of data within Reg-ent grows
- Partnering with the American Board of Otolaryngology (ABOto) to have Reg-ent participation assist members with meeting Maintenance of Certification (MOC) requirements
- Using data within Reg-ent to help inform new measure development.

The investment of time and subscription and application fees are nominal when compared to the broader benefits to the practice of otolaryngology.

— Lisa E. Ishii, MD, MHS ■



## Academy maintains clinically appropriate coding edits

The National Correct Coding Initiative (NCCI), a division of the Centers for Medicare and Medicaid Services (CMS), periodically reaches out to the Academy to request feedback on proposed changes to various Current Procedure Terminology (CPT) codes. When implemented, these modifications, called procedure to procedure (PTP) edits, can directly impact physician reporting and billing for certain procedures (for example, what services can be reported together on the same date of service).

In response to proposed PTP edits for CPT codes describing laryngectomies

paired with cervical lymphadenectomies, the Academy's CPT team submitted written comments advocating against coding edits. This would disallow these procedures to be performed on the same patient on the same day.

Following the Academy's advocacy effort, NCCI agreed with the Academy's rationale and decided against the implementation of the proposed modifications on October 1, 2017. In response, the Academy thanked NCCI for taking the CPT team's concerns into consideration when making the final determination. ■

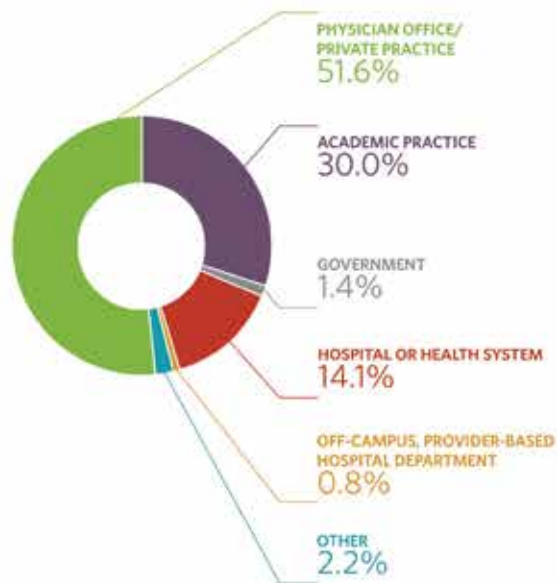


## AAO-HNS 2017 SOCIOECONOMIC SURVEY

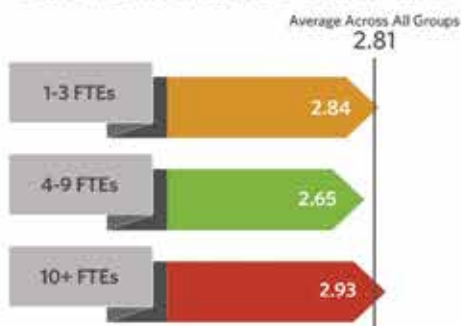
### The Academy Partnered with the Association of Otolaryngology Administrators to Conduct the 2017 Socioeconomic Survey

This summer, the Academy partnered with the Association of Otolaryngology Administrators (AOA) to conduct the 2017 socioeconomic survey. This new partnership afforded members more detailed practice data to help them navigate the ever-changing healthcare environment. The survey was distributed to all members, excluding Residents, Associate Members, Affiliate Members, Scientific Fellows, and Non-Domestic Otolaryngologists. A summary of results and trends is included in this issue. Comprehensive data will be available in the coming months. Keep an eye on your weekly *OTO News* and Academy webpage (Member Log in required) <http://www.entnet.org/content/socioeconomic-data>. ■

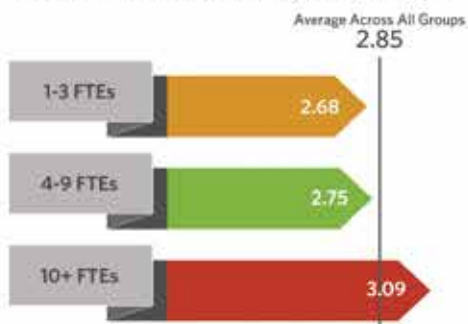
### WORK SETTING



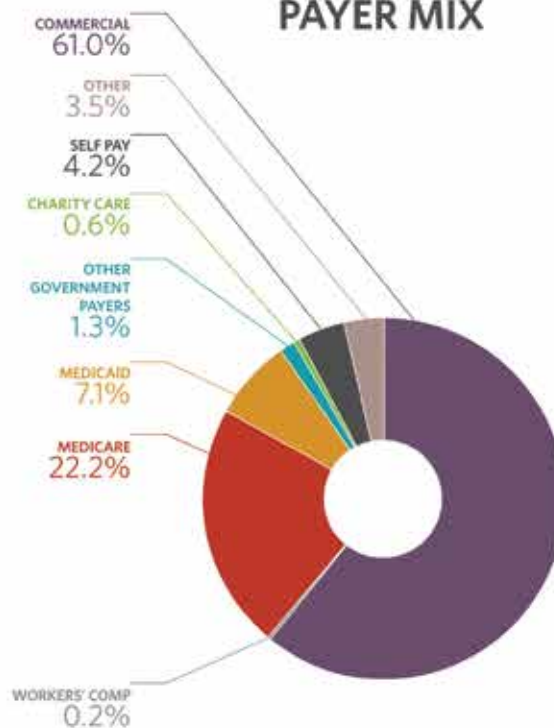
### TOTAL CLINICAL STAFF (NURSES, PAs, TECHS) PER FTE PHYSICIAN BY GROUP SIZE



### TOTAL NON-CLINICAL ADMINISTRATIVE STAFF PER FTE PHYSICIAN BY GROUP SIZE



### PAYER MIX







# AAO-HNS 2017 SOCIOECONOMIC SURVEY

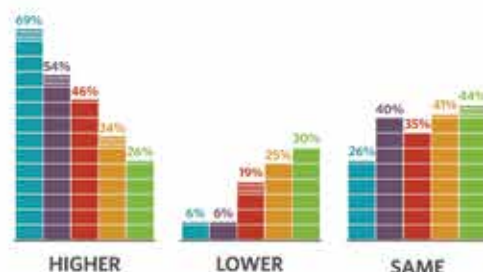
## PERSONAL INCOME (2016 vs. 2015)

Compared with 2015, was your 2016 personal income (salary only) higher, lower or about the same?

By Gender: **Women** **Men**

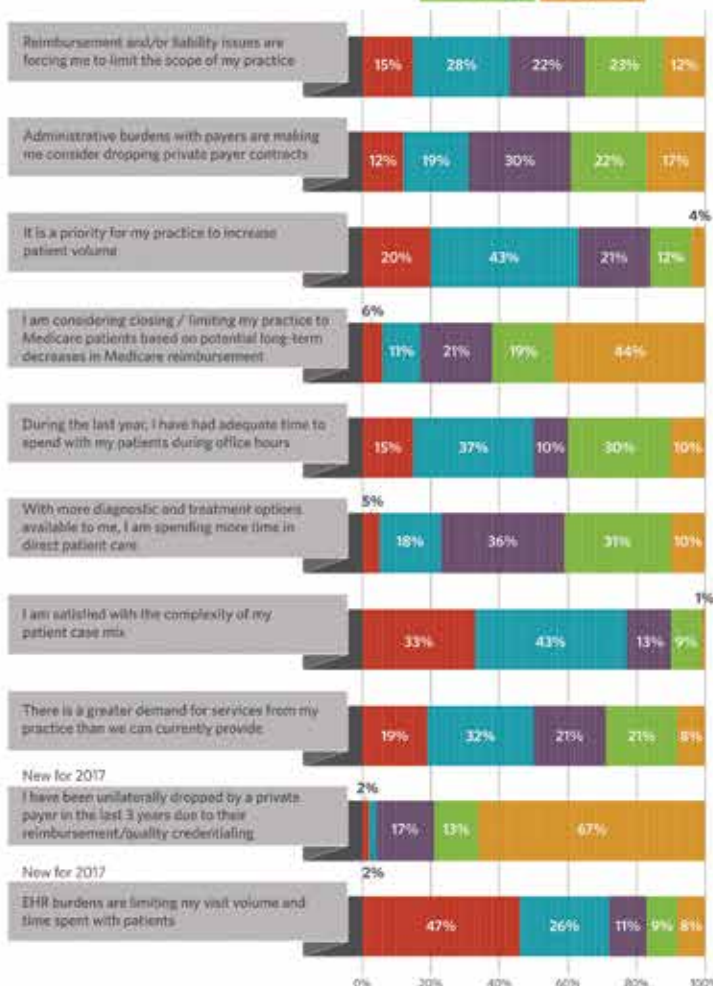


By Years in Practice: **1 to 5** **6 to 10** **11 to 15** **16 to 20** **> 21**



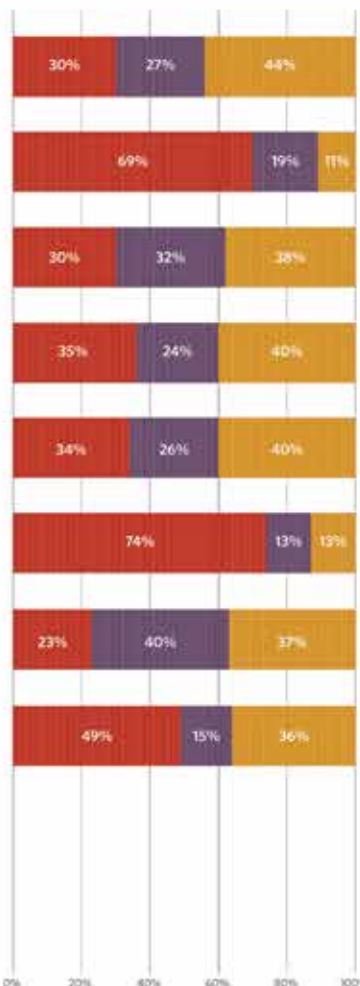
## 2017 SOCIOECONOMIC OPINIONS

**Strongly Agree** **Somewhat Agree** **Neutral**  
**Somewhat Disagree** **Strongly Disagree**



## 2014 SOCIOECONOMIC OPINIONS

**Agree** **Neutral** **Disagree**





# You care for patients. We care for YOU.

**A**AO-HNS offers value-added benefits and enhanced resources that help you achieve excellence and provide the best ear, nose, and throat care to your patients. While you have been busy caring for your patients, we have been busy caring for you. Together, we have accomplished a lot, including:

- Two new and three updated Clinical Practice Guidelines.
- Reg-ent<sup>SM</sup> CMS QCDR and QR Designations for both 2016 and 2017. Reg-ent will support Quality Performance, Advancing Care Information (ACI), and Improvement Activities (IA) reporting categories of MIPS beginning in 2017.
- Instruction Courses included in registration and free education session webcasts for full conference attendees at the AAO-HNSF 2017 Annual Meeting & OTO Experience.
- *OTO Open* launch, the AAO-HNSF's peer-reviewed gold open access journal.

As healthcare evolves in these turbulent times, we are continuing our efforts to provide our members with meaningful programs and services. We are excited about the following new initiatives we have underway:

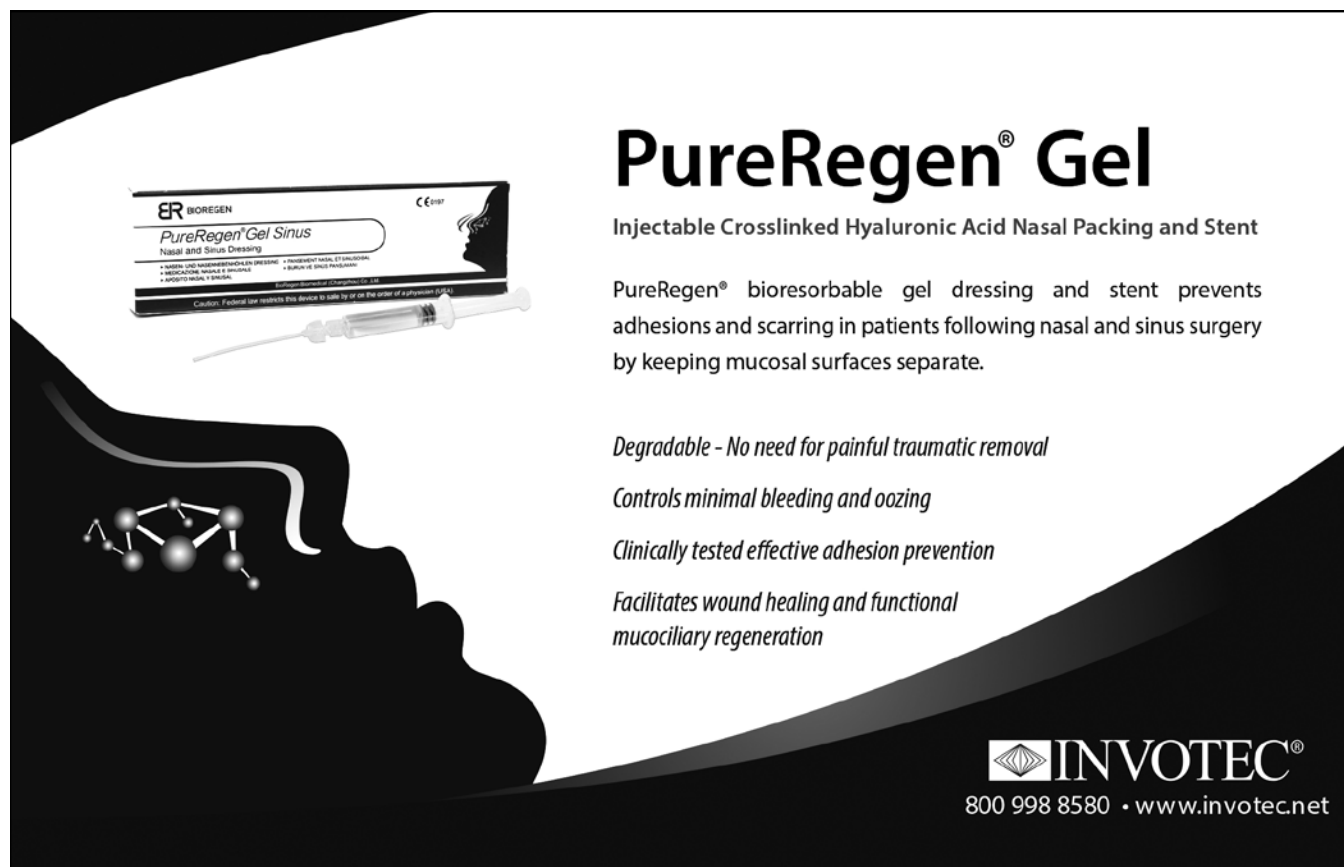
- Member+, a program offering Academy members access to over 200 online education activities
- OTO Source, a comprehensive curriculum that supports both residents and practicing otolaryngologists
- Growth and expansion of Reg-ent beyond public reporting including maintenance of certification, research, and post-market surveillance capabilities
- Quality measures development projects including Neurotology, Age-related Hearing Loss, Measures directly from CPG Key Action Statements, and Rhinoplasty
- Continued advocacy efforts at both the federal and state levels

In addition to the most recent initiatives, the Academy offers its members value-added

benefits, including:

- Listing in Find an ENT
- Participation in Reg-ent, the first otolaryngology clinical data registry (*additional fees apply, participation open to domestic members only*)
- Member discount for the AAO-HNSF Annual Meeting & OTO Experience
- Access to the AcademyU<sup>®</sup> learning platform
- Subscriptions to the scientific journal, *Otolaryngology–Head and Neck Surgery* and the *Bulletin*
- *OTO News*, your personalized weekly eNewsletter
- Connections to colleagues on ENTConnect and through the member online directory

We are proud of our collective accomplishments, value you as members, and look forward to serving you and the specialty for years to come. Renew your membership today at [www.entnet.org/renew](http://www.entnet.org/renew) to maintain access to professional development opportunities, practice management resources, and publications. ■



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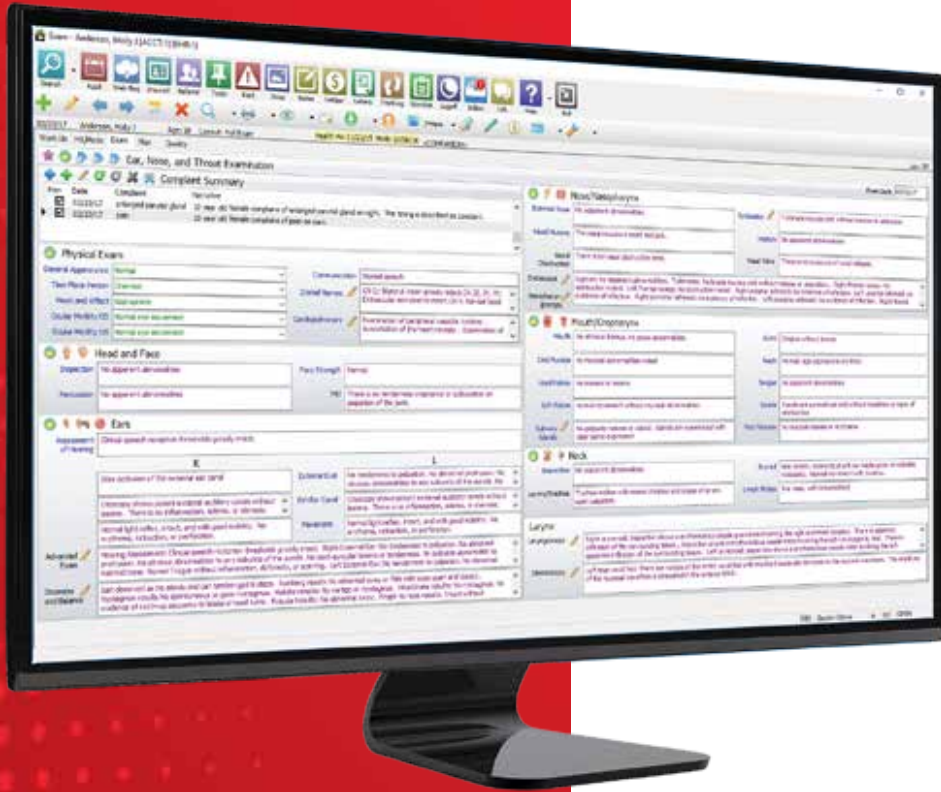
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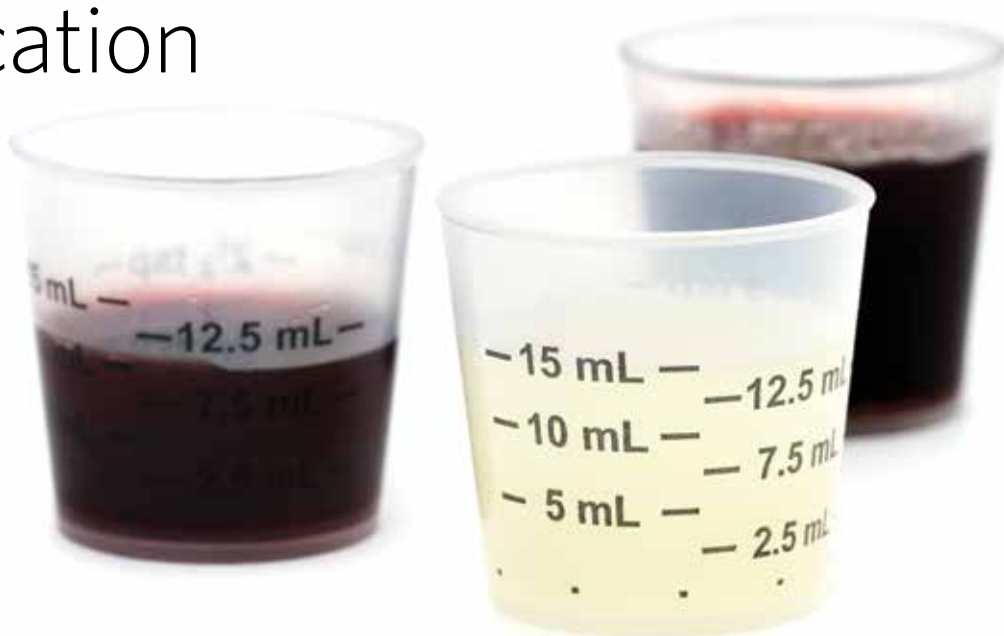
# Strategies to avoid patient harm when prescribing liquid medication

■ **Karthik Balakrishnan, MD, MPH,** and **Michael J. Brenner, MD,** for the Patient Safety and Quality Improvement (PSQI) Committee

Liquid medications are frequently used in otolaryngology, whether for pediatric patients after common operations such as adenotonsillectomy, or for adult patients recovering from head and neck operations. Unlike other forms of medication, liquid medications are usually measured out each time a dose is administered, creating recurring opportunities for dosing errors. Indeed, some studies suggest that parents of pediatric patients may make dosing errors “over 40 percent of the time” (Yin HS et al *Pediatrics* 2016). With liquid analgesics, narcotics, and antibiotics in common use in otolaryngology, our patients may be particularly vulnerable to this problem.

As prescribing providers, we can play a major role in reducing these errors by becoming more aware of these risks and by employing simple prevention strategies. Here’s what you can do to reduce this problem and reduce your patients’ risk from liquid medications.

Many clinicians are familiar with the Choosing Wisely campaign ([www.choosingwisely.org](http://www.choosingwisely.org)), which aims to use simple, evidence-based tips to improve the quality and safety of care while reducing costs. The Institute of Safe Medication Practices ([www.ismp.org](http://www.ismp.org)) and the American Society of Health-System Pharmacists have produced a list of Choosing Wisely recommendations that includes the following:



*“Do not prescribe or administer oral liquid medications using teaspoon or tablespoon for measurement; use only milliliters (mL) when measuring with an approved dosing device (e.g., medication cup or oral syringe).”*

Dr. Shannon Manzi, director of the Clinical Pharmacogenomics Service and Pharmacy Manager for ICU and Emergency Services at Boston Children’s Hospital and Harvard Medical School, said that parents and caregivers frequently mistake measuring spoons of different sizes (tablespoon and teaspoon). She also observed that non-English-speaking individuals and those with lower health literacy might be especially vulnerable to such errors. “Clearly, a three-fold overdose of certain medications could result in harm.”

Chad Brummett, MD, director of Clinical Research in the Department of Anesthesiology at the University of Michigan, noted that when it comes to opioid medications in particular, “the results of such mistakes can

be devastating, including respiratory arrest and death.”

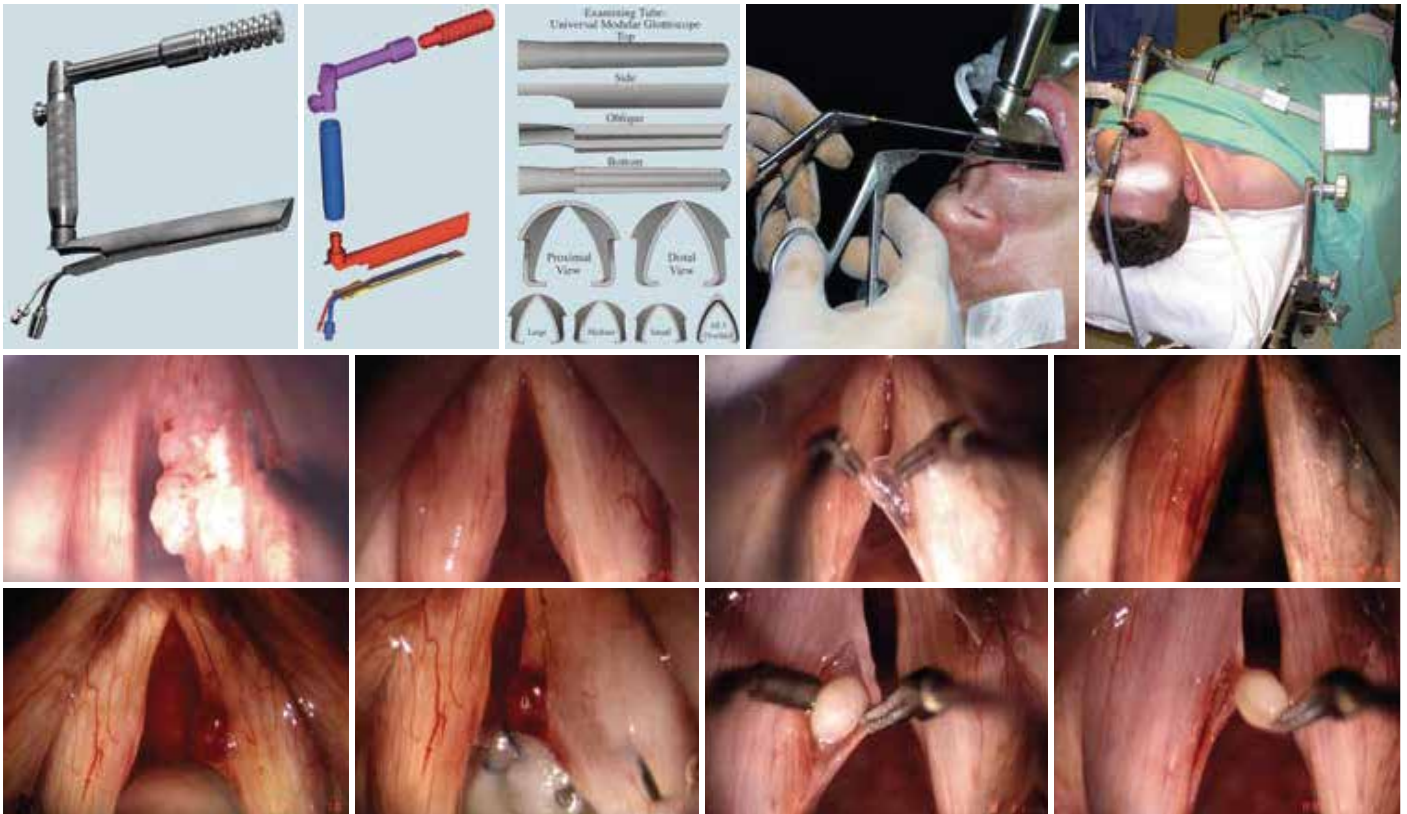
With over 500,000 children undergoing tonsillectomy in the United States each year (Boss EF J *Pediatrics* 2012) and many more patients requiring liquid medications for other reasons, otolaryngologists have the opportunity to make a difference in this problem.

**1. Use only metric units (milliliters or milligrams) when prescribing. If prescribing in milligrams, make sure that the correct medication concentration (milligrams per milliliter) is prescribed.** Many practices and institutions have already made this change, particularly with the advent of computerized prescribing and order entry. Kevin Graner, R.Ph., senior manager of Pharmacy at the Mayo Clinic, noted that for inpatient prescribing at Mayo, all medications are ordered in milligrams. The ordering system then automatically converts dosages

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to milliliters for pharmacists and nurses to dispense and administer doses. On the outpatient side, electronic ordering records the liquid medication concentration and forces prescribing in milliliters so that caregivers and patients do not have to do dose calculations themselves. Boston Children's Hospital takes the same approach, said Dr. Manzi. Both institutions have essentially eliminated free text prescribing to further reduce risk.

For practices using paper or free text prescribing, extra attention may be warranted. Some options to reduce risk might include preprinted prescriptions to improve legibility; double-checking prescriptions to confirm correct dose, concentration, and units; and standardization of prescription format, language, and units.

## 2. Use oral syringes with metric (milli-liter) dose markings to administer all liquid medications.

A recent randomized controlled trial demonstrated that **84 percent of parents make at**

**least one dosing error when providing their child medication**, and 21 percent gave double the prescribed dose or more at least once. "The odds of dosing errors were 4.6 times higher when medication cups were used compared to oral syringes." This finding held true across different patient language and health literacy groups. No difference was seen between syringes with 0.2 mL and 0.5 mL markings. However, the use of teaspoon markings increased the rate of errors compared to milliliter markings (Yin HS et al *Pediatrics* 2016).

Mr. Graner noted that Mayo Clinic has converted to oral syringes with only milliliter markings and that many syringe manufacturers are making the same shift. Dr. Manzi suggests one future intervention could be to require retail pharmacies to provide oral syringes with metric units for all liquid prescriptions and labeling over-the-counter liquid medications with dose strength (milligrams) and corresponding milliliter dose volumes. A current option is to educate patients at the time of prescription that only oral syringes should be used.

## 3. Consider opioid prescriptions with particular care.

While the epidemic of opioid addiction has received a great deal of news attention recently, Dr. Brummett has demonstrated that persistent opioid use and dependence (lasting greater than 90 days) begins after even minor medical procedures in over five percent of adult patients, compared to four-tenths percent of nonoperated control patients. Patients at higher risk included those with mood disorders, tobacco, alcohol, or other substance abuse history, anxiety, and preoperative pain disorders.

"Chronic opioid use is independently associated with morbidity and mortality and should be considered by patients and providers when assessing postoperative risk and clinical care," he said.

We hope that our fellow otolaryngologists will consider these issues and preventive steps when prescribing liquid medications and opioids. Our specialty has an important role to play in keeping our patients safe from these harms. ■



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# Evaluation of neck mass in adults

Adapted from the September 2017 Supplement to *Otolaryngology–Head and Neck Surgery*. Read the guideline at [www.otojournal.org](http://www.otojournal.org).

**T**he primary purpose of the *Clinical Practice Guideline: Evaluation of the Neck Mass in Adults* is to promote the efficient, effective, and accurate diagnostic work-up of neck masses to ensure that adults with potentially malignant disease receive prompt diagnosis and intervention to optimize outcomes. This guideline does not apply to children. Instead, this guideline is restricted to addressing the appropriate work-up of an adult patient with a neck mass that may be malignant in order to expedite diagnosis and referral to a head and neck cancer specialist.

The 2017 guideline was chaired by **Melissa A. Pynnonen, MD**, with **M. Boyd Gillespie, MD, MSc**, and **Benjamin R. Roman, MD, MSHP**, serving as assistant chairs, and **Richard M. Rosenfeld, MD, MPH**, as the methodologist, and **David E. Tunkel, MD**, as methodologist-in-training.

“Neck masses are common in adults, but often the underlying etiology is not easily identifiable. Timely diagnosis of a neck mass due to metastatic squamous cell carcinoma, or HNSCC, is paramount because delayed

diagnosis directly impacts tumor stage and worsens prognosis. The incidence of HNSCC of the oropharynx in particular is on the rise—in part as a consequence of infection with the human papilloma virus (HPV). Expediting the diagnosis of HNSCC is the principal quality improvement opportunity for this guideline,” said Dr. Pynnonen.

The guideline is endorsed to date by American Academy of Physician Assistants, American Academy of Emergency Medicine, American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Head and Neck Society, American Society for Clinical Pathology, Head and Neck Cancer Alliance, Society of Otorhinolaryngology Head-Neck Nurses, and Triological Society.

The full guideline, as well as other resources, is available at <http://www.entnet.org/content/clinical-practice-guideline-evaluation-neck-mass-adults> and in *Otolaryngology–Head and Neck Surgery* as published at [www.otojournal.org](http://www.otojournal.org).

The target patient for this guideline is 18 years or older with a neck mass. The target clinician for this guideline is the first clinician a patient with a neck mass encounters. This includes clinicians in

primary care, dentistry, and emergency medicine, as well as pathologists and radiologists who have a role in diagnosing neck mass.

## Guideline key action statements

### 1. Avoidance of antibiotic therapy

Clinicians should **not** routinely prescribe antibiotic therapy for patients with a neck mass unless there are signs and symptoms of bacterial infection.

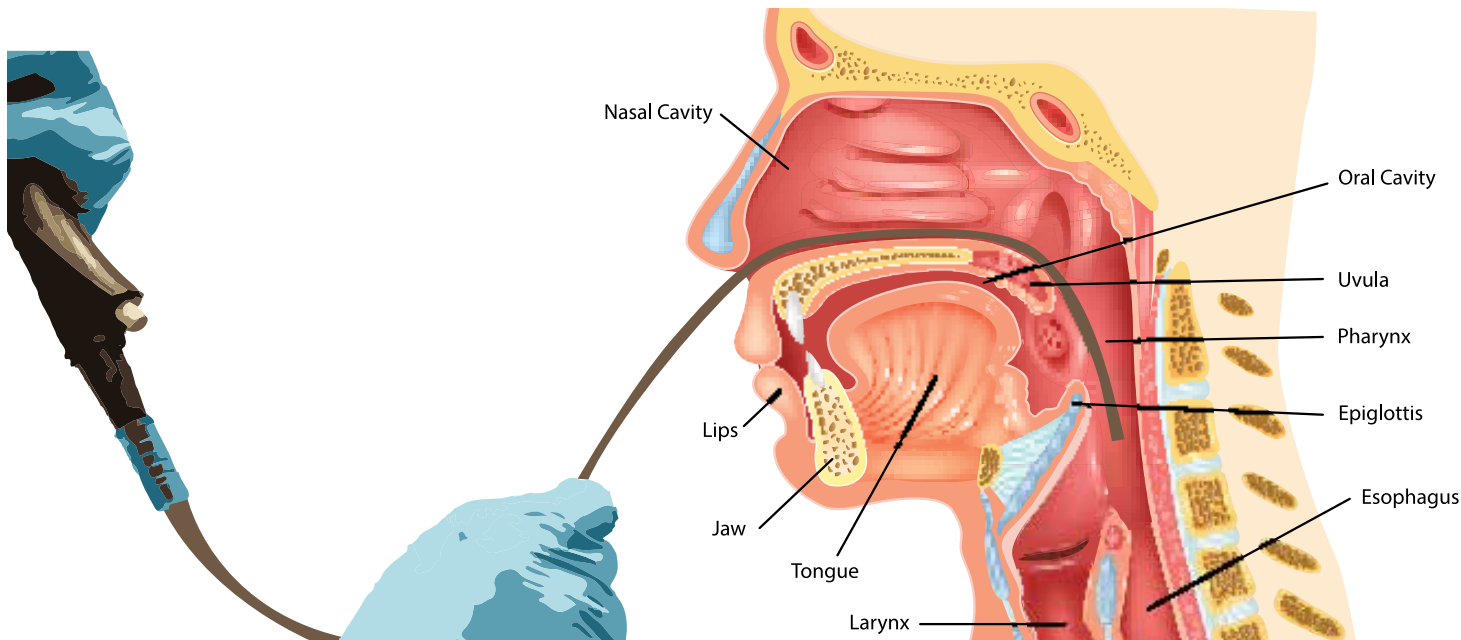
### 2a. Stand-alone suspicious history

Clinicians should identify patients with a neck mass who are at increased risk for malignancy because the patient lacks a history of infectious etiology and the mass has been present for two weeks or greater without significant fluctuation or the mass is of uncertain duration.

### 2b. Standalone suspicious physical examination

Clinicians should identify patients with a neck mass who are at increased risk for malignancy based on one or more of these physical examination characteristics: fixation to adjacent tissues, firm consistency, size





greater than 1.5 cm, and/or ulceration of overlying skin.

## 2c. Additional suspicious signs and symptoms

Clinicians should conduct an initial history and physical examination for all adults with a neck mass to identify those patients with other suspicious findings that represent an increased risk for malignancy.

## 3. Follow-up of the patient not at increased risk

For patients with a neck mass who are not at increased risk for malignancy, clinicians or the designees should advise patients of criteria that would trigger the need for additional evaluation. Clinicians or their designees should also document a plan for followup to assess resolution or final diagnosis.

## 4. Patient education

For patients with a neck mass who are deemed at increased risk for malignancy, clinicians or their designees should explain to the patient the significance of being at increased risk and explain any recommended diagnostic tests.

## 5. Targeted physical examination

Clinicians should perform, or refer the patient to a clinician who can perform, a targeted physical examination (including visualizing the mucosa of the larynx, base of tongue, and pharynx), for patients with a neck mass deemed at increased risk for malignancy.

## 6. Imaging

Clinicians should order a neck computed tomography (or magnetic resonance imaging) with contrast for patients with a neck mass deemed at increased risk for malignancy.

## 7. Fine needle aspiration (FNA)

Clinicians should perform FNA instead of open biopsy, or refer the patient to someone who can perform FNA, for patients with a neck mass deemed at increased risk for malignancy when the diagnosis of the neck mass remains uncertain.

## 8. Cystic masses

For patients with a neck mass deemed at increased risk for malignancy, clinicians should continue evaluation of patients with a cystic neck mass, as determined by FNA or imaging studies, until a diagnosis is obtained and should not assume the mass is benign.

## 9. Ancillary tests

Clinician should obtain additional ancillary tests based on the patient's history and physical examination when a patient with a neck mass is at increased risk for malignancy and/or does not have a diagnosis after FNA and imaging.

## 10. Examination under anesthesia of the upper aerodigestive tract before open biopsy

Clinicians should recommend examination of the upper aerodigestive tract under anesthesia, before open biopsy, for patients with a neck

mass who are at increased risk for malignancy and without a diagnosis or primary site identified, with FNA, imaging, and/or ancillary tests.

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](http://oto.sagepub.com/content/148/1_suppl/S1.long))

### Guideline authors

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### Disclaimer

The clinical practice guideline is provided for information and educational purposes only. It is not intended as a sole source of guidance in evaluating neck masses. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. The guideline is not intended to replace clinical judgment or establish a protocol for all individuals with this condition and may not provide the only appropriate approach to diagnosing and managing this program of care. As medical knowledge expands and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions but are not absolute. Guidelines are not mandates; these do not and should not purport to be a legal standard of care. The responsible physician, in light of all circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNSF emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care, or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results. ■





## PATIENT INFORMATION

# Adult Neck Mass Follow-up

### QUESTION

Why do I need to know about my neck mass?

### ANSWER

A neck mass is an abnormal lump in the neck. A neck mass may be caused by infection, benign tumor, or a cancerous tumor. A neck mass from infection should go away completely when the infection goes away. If it does not, your healthcare provider will help you to choose tests to determine the cause of your neck mass.

What should I do?

- If you were given antibiotics, take them as prescribed.
- Once each week, check the size of the neck mass using your fingertips.
- Follow up with your provider to be sure that the neck mass decreases in size over time.
- Be sure to follow through with any tests your provider ordered.

How do I check the size of my neck mass?

Once each week use your fingertips to check the size of the mass. How wide is the mass? One fingertip wide? Two fingertips wide? How does that compare to the size last time you checked? The mass should get smaller over time. A mass due to infection should go away completely typically in 2 or 3 weeks.

Contact your provider if:

- The mass gets larger
- The mass does not go away completely.
- The mass goes away but then comes back

What else should I look for?

Notify your provider if you have:

- Difficulty or pain with swallowing
- Neck pain or throat pain
- Mouth sores or tooth pain
- Ear pain or hearing loss on the same side as the lump in your neck
- Change in voice
- Unexplained weight loss
- Fever over 101 degrees Fahrenheit

How should I follow up with my provider?

You and your provider may stay in contact by phone, through electronic messages, by mail, or in person at the provider's office. You may need to go back to your provider's office for a repeat examination.

**No matter how you follow up with your provider, be sure that the mass has gone away. If the mass does not go away, your provider will help you decide what to do next.**

**SOURCE:** Pynnonen, MA, Gillespie, MB, Rosenfeld RM, et al. Clinical Practice Guideline: Evaluation of the Neck Mass in Adult. *Otolaryngol Head Neck Surg.* 2017; 157(2 Suppl):S1-S30.



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#### ABOUT THE AAO-HNS/F

The American Academy of Otolaryngology-Head and Neck Surgery ([www.entnet.org](http://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 for Adults with a Neck Mass

### QUESTION

What does it mean that I have a neck mass at increased risk for malignancy?

### ANSWER

The mass in your neck may indicate a serious medical problem. It does not mean you have cancer, but it does mean you need more evaluation to make a diagnosis.

Common symptoms in patients with a neck mass at increased risk for malignancy include:

- The mass lasts longer than 2-3 weeks
- Voice change
- Trouble or pain with swallowing
- Trouble hearing or ear pain on the same side as the neck mass
- Sore throat
- Unexplained weight loss
- Fever over 101 degrees Fahrenheit

What do I do next?

Your provider will ask about medical history and examine your head and neck. Your provider may order tests or refer you to a specialist.

How urgently should I be evaluated?

Your provider will want to make sure you have a thorough evaluation, testing and follow-up within a short period of time. It is important you discuss this timeline with your provider and make sure there is a plan for follow-up after testing. It is important for you to follow this neck mass until it goes away or until you have a diagnosis.

**SOURCE:** Pynnonen, MA, Gillespie, MB, Rosenfeld RM, et al. Clinical Practice Guideline: Evaluation of the Neck Mass in Adult. *Otolaryngol Head Neck Surg.* 2017; 157(2 Suppl):S1-S30.



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## PATIENT INFORMATION

# Examination Under Anesthesia: What Should the Adult Patient Expect?

QUESTION	ANSWER
What is examination (endoscopy) under anesthesia?	Examination under anesthesia is performed by a surgeon to evaluate the back of your throat, voice box, the back of your nose, upper trachea (breathing tube) and upper esophagus (swallowing tube).
Why do I need an examination under anesthesia?	This test allows a complete evaluation of the back of your nose and throat, your voice box, the windpipe, and esophagus (swallowing tube). If your doctor sees an area of concern, he/she will take a small piece of tissue for evaluation (biopsy).
How is this examination performed?	Examination under anesthesia is performed in the operating room. You will be asleep with general anesthesia. A scope with attached camera is inserted through your mouth and into your throat, voice box, windpipe and esophagus.
How will I feel after the procedure?	After general anesthesia, you may feel sleepy for a day. You will be able to eat and drink as you did before the procedure. You will receive medication for pain. <b>You may have the following symptoms:</b> <ul style="list-style-type: none"> <li>■ A sore throat lasting 1-2 days</li> <li>■ Hoarse voice</li> <li>■ Coughing or spitting up small amount of blood for 1-3 days</li> </ul>
What are the risks of examination under anesthesia?	A risk is a problem that you might have. <b>Some risks include:</b> <ul style="list-style-type: none"> <li>■ Reaction to anesthesia</li> <li>■ Bleeding that may recur where the tissue sample were taken</li> <li>■ Damage to teeth</li> <li>■ Swelling where tissue samples were taken may cause difficulty breathing</li> <li>■ Damage to the back of the throat or esophagus (swallowing tube)</li> </ul>
When will I receive my results?	After the examination under anesthesia your doctor will be able to tell you what he or she saw and if biopsies were taken. Biopsy results will take at least a few days, sometimes longer. Your doctor will call you or schedule a follow-up visit to review the biopsy results.
Call your doctor if you experience:	<ul style="list-style-type: none"> <li>■ Severe bleeding or any bleeding longer than 3 days</li> <li>■ Fever over 101 degrees Fahrenheit</li> <li>■ Inability to swallow</li> <li>■ Vomiting</li> <li>■ Difficulty breathing</li> </ul>

**SOURCE:** Pynnonen, MA, Gillespie, MB, Rosenfeld RM, et al. Clinical Practice Guideline: Evaluation of the Neck Mass in Adult. *Otolaryngol Head Neck Surg.* 2017; 157(2 Suppl):S1-S30.



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## PATIENT INFORMATION

# Neck Mass Biopsy:

## What Should the Adult Patient Expect?

### QUESTION

What is a biopsy?

### ANSWER

A biopsy involves taking a sample of tissue from the neck mass. This sample of tissue is looked at under the microscope by a pathologist (a specialized doctor), to make a diagnosis. A biopsy is a common test to check for cancer. There are different types of biopsies that can be done. The type of biopsy performed is based on your history and the location of your mass.

What are the different type of biopsies?

#### Fine Needle Aspiration Biopsy (FNA)

An FNA is the best initial test to diagnose a neck mass. A small needle is put into the mass and tissue is pulled out. An FNA is often done in your doctor's office. It is well-tolerated by most patients.

Risks include:

- Discomfort
- Infection
- Bruising
- Not getting enough tissue for a diagnosis

#### Core Biopsy

A core biopsy is another way to diagnose a neck mass. A core biopsy may be done instead of or after an FNA. A core biopsy uses a slightly larger needle and gets a larger piece of tissue. It is well tolerated and has a low risk of complications.

Risks include:

- Bleeding
- Infection
- Bruising
- Not getting enough tissue for a diagnosis
- Discomfort

#### Open Biopsy

An open biopsy is another way to diagnose a neck mass. It is a more invasive procedure. Open biopsy is done by a surgeon in the operating room and you will need anesthesia. An open biopsy may remove only portion of the mass or the whole mass. Because open biopsies are more invasive, there is a higher risk for complications.

Risks include:

- Complications of anesthesia
- Discomfort
- Infection
- Scarring
- Bleeding
- Nerve injury (numbness, paralysis)

**SOURCE:** Pynnonen, MA, Gillespie, MB, Rosenfeld RM, et al. Clinical Practice Guideline: Evaluation of the Neck Mass in Adult. *Otolaryngol Head Neck Surg.* 2017; 157(2 Suppl):S1-S30.



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E-mail: [mark.inman@osumc.edu](mailto:mark.inman@osumc.edu)  
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Letters of interest with accompanying CV should be directed to: Greg A. Kreml, MD, FACS, c/o Nancy Geiger, Department of Otolaryngology Head and Neck Surgery, P.O. Box 26901, Room AAT 1400, Oklahoma City, OK 73126-0901 or via e-mail [nancy-geiger@ouhsc.edu](mailto:nancy-geiger@ouhsc.edu). The University of Oklahoma is an Affirmative Action and Equal Opportunity Employer.



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Direct inquiries to:

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[zeitels.steven@mgh.harvard.edu](mailto:zeitels.steven@mgh.harvard.edu)



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## **Otolaryngology**

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McFarland Clinic is seeking a BE/BC Otolaryngologist to join our extraordinary team and provide exceptional care within Iowa's largest multidisciplinary clinic. Consistently ranked in the top 10 "Best Places to Live" by Money Magazine and CNNMoney.com, this thriving town has been ranked in the top 3 cities in the country for job growth.

- daVinci Robot and the Olympus Video System
- In-office laryngeal biopsies
- New state-of-the-art minor procedure room
- Epic EMR System
- Weekly cancer case conference
- Established, collegial team and support staff
- Physician owned and governed
- Large, established referral network
- One of the least litigious states in the country
- "#1 Best State to Practice Medicine" - *WalletHub*



Ames, Iowa is a family friendly town that offers top-quality education with the best school district in the state. This Big 12 city has been voted the "Best College Town" by *Livability.com*. Our proud community boasts the cultural, recreational and entertainment amenities of a big city while maintaining the charm that you would expect from small-town living. Welcome to Ames, a place that will quickly become your hometown.

EEO/AA Employer/Protected Vet/Disabled

**Contact Doug Kenner**

**866.670.0334 or [dkenner@mountainmed.net](mailto:dkenner@mountainmed.net)**



**McFarland Clinic PC**

**Extraordinary Care, Every Day**

Along with nationally recognized partners at Froedtert Hospital and Children's Hospital of Wisconsin, the Department of Otolaryngology and Communication Sciences at the Medical College of Wisconsin seeks outstanding academic faculty at the Assistant Professor rank to join our team.



Full-time academic faculty positions are available that provide competitive compensation and benefits, educational opportunities, and protected research time with dedicated resources. Applicants must be fellowship trained in the sub-specialty, certified or eligible for certification by the American Board of Otolaryngology, and eligible for a Wisconsin license. Current positions are available in:

- Head and Neck Surgical Oncology and Reconstruction
- Pediatric Otolaryngology

Email letter of interest and CV to:

John S. Rhee, MD, MPH

John C. Koss Professor and Chairman

Department of Otolaryngology and Communication Sciences

Medical College of Wisconsin

Milwaukee, Wisconsin

[jrhee@mcw.edu](mailto:jrhee@mcw.edu)

The Medical College of Wisconsin is an Equal Opportunity/Affirmative Action Employer.

### **Pediatric Otolaryngologist – Fellowship Trained-Academic Practice Opportunity near Chicago – Loyola University Medical Center**

The Department of Otolaryngology at Loyola University Health System and Loyola University Chicago Stritch School of Medicine is currently inviting applications for a Fellowship-Trained Pediatric Otolaryngologist.

The ideal candidate will have an interest in academic otolaryngology, a commitment to resident and medical student education and clinical research, and a desire to build a busy academic practice in all facets of Pediatric Otolaryngology. This physician will enjoy working near one of the finest cities in the United States for a large academic group with a strong reputation for clinical care, education, and research.

The Department of Otolaryngology – Head & Neck Surgery at Loyola University Health System is among the top Ear, Nose and Throat (ENT) programs in Illinois and in the country, according to U.S. News & World Report. This Department is consistently identifying ways to improve its clinical, training, and research programs.

Candidates should be board-certified or board-eligible by the American Board of Otolaryngology and must be licensed or eligible to practice in Illinois. Interested candidates should address a cover letter and CV to Dr. Sam Marzo, Chair of Otolaryngology, and email to Michelle Pencyla, Director, Physician Recruitment, at [mpencyla@lumc.edu](mailto:mpencyla@lumc.edu).

*Loyola is an equal opportunity and affirmative action employer/educator with a strong commitment to diversifying its faculty.*



### **Otolaryngology – Head & Neck Surgery Faculty**

The Department of Otolaryngology – Head and Neck Surgery at Rutgers Robert Wood Johnson Medical School, one of the nation's leading comprehensive medical schools, is currently recruiting surgeons to join our growing academic faculty. We seek candidates who can contribute to our clinical, education and research missions.

Robert Wood Johnson Medical School and its principal teaching affiliate, Robert Wood Johnson University Hospital (RWJUH) comprise New Jersey's premier academic medical center. RWJUH is a 965-bed, Level I Trauma Center, with New Jersey's only Level II Pediatric Trauma Center, as well as the NCI-designated Comprehensive Cancer Center (Rutgers Cancer Institute of New Jersey) and The Bristol-Myers Squibb Children's Center at RWJUH.

#### **Head and Neck Surgical Oncologists (2) Pediatric Otolaryngologist Rhinologist**

Qualified candidates must be BE/BC by the American Board of Otolaryngology. Salary and benefits are competitive and commensurate with experience.

Please send a letter of interest and a curriculum vitae to:  
**P. Ashley Wackym, MD, Professor and Chair**  
**Department of Otolaryngology – Head and Neck Surgery**  
**Rutgers Robert Wood Johnson Medical School,**  
**10 Plum Street, 8th Floor**  
**New Brunswick, NJ 08901-2066;**  
**email [ashley.wackym@rutgers.edu](mailto:ashley.wackym@rutgers.edu)**

Rutgers, The State University of New Jersey, is an Affirmative Action/Equal Opportunity Employer, M/F/D/V



### **Multiple Positions Available**

The University of Florida Department of Otolaryngology is seeking applicants who wish to pursue an academic career in Pediatric Otolaryngology, Otolaryngology/Neurotology or General Otolaryngology at the rank of Assistant, Associate, or Full Professor. Track and rank will be commensurate with experience. The department has 11 full-time faculty members and 15 residents. The desired candidate should possess a strong commitment to both clinical practice as well as resident teaching. Applicants should be board certified or board eligible and licensed (or eligible) to practice in Florida. Significant relevant clinical experience and/or fellowship training in the chosen field is desired. Salary is negotiable and will be commensurate with experience and training.

**To Apply, please go to [explore.jobs.ufl.edu](http://explore.jobs.ufl.edu), search using "Otolaryngology, Gainesville". After applying, please send your CV and cover letter to the appropriate person below:**

**Pediatric Otolaryngology**  
Department of Otolaryngology  
Attn: **William Collins, MD**  
University of Florida  
PO Box 100264  
Gainesville, FL 32610-0264  
Email: [william.collins@ent.ufl.edu](mailto:william.collins@ent.ufl.edu)

**Otolaryngology/Neurotology**  
Department of Otolaryngology  
Attn: **Neil Chheda, MD**  
University of Florida  
PO Box 100264  
Gainesville, FL 32610-0264  
Email: [neil.chheda@ent.ufl.edu](mailto:neil.chheda@ent.ufl.edu)

**General Otolaryngology**  
Department of Otolaryngology  
Attn: **John D. Harwick, MD, FFAOA**  
University of Florida  
PO Box 100264  
Gainesville, FL 32610-0264  
Email: [john.harwick@ent.ufl.edu](mailto:john.harwick@ent.ufl.edu)

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



## Otology & Neurotology Faculty Position

The Department of Otorhinolaryngology-Head & Neck Surgery is recruiting an otologist/neurologist to join its expanding department. This is a unique opportunity to build a subspecialty academic practice at the country's largest medical center in an urban setting. The ideal candidate will have a focus on clinical practice. The position entails direct contact with both residents and medical students. Clinical research interests are encouraged.

Academic appointment commensurate with experience. Fellowship training in otology/neurotology required. Excellent salary and benefits. Outstanding opportunities for teaching and research.

Please submit your CV and application here: [www.ent4.me/recruit](http://www.ent4.me/recruit)

*Interest and questions may be directed to:*

**Martin J. Citardi, MD (chair)**  
McGovern Medical School  
The University of Texas Health Science Center at Houston  
Department of Otorhinolaryngology-Head & Neck Surgery  
Fax: 713-383-1410 Email: [martin.j.citardi@uth.tmc.edu](mailto:martin.j.citardi@uth.tmc.edu)

UTHealth is an EEO/AA employer. UTHealth does not discriminate on the basis of race, color, religion, gender, sexual orientation, national origin, genetics, disability, age, or any other basis prohibited by law. EOE/M/F/Disabled/Vet.



The Division of Head and Neck surgery in the Department of Otolaryngology - Head & Neck Surgery at Emory University School of Medicine, Atlanta, GA seeks to add a fellowship-trained Head and Neck ablative and microvascular reconstructive surgeon at the rank of Assistant or Associate Professor. Duties will include resident and fellow teaching and a clinical practice primarily involving mucosal tumors of the upper aerodigestive tract and microvascular reconstruction.

Our current practice features four full-time, fellowship-trained Head and Neck Surgeons and a new, state-of-the-art Head and Neck Clinic on the campus of Emory University Hospital Midtown. Multidisciplinary care in conjunction with Winship Cancer Center includes exceptional Medical and Radiation Oncology as well as the full complement of ancillary services. Applicants must be Board Certified or Board Eligible.

Compensation will be commensurate with experience.

**Interested applicants should forward letters of inquiry and curriculum vitae to:**

Mark W. El-Deiry, MD, FACS  
Associate Professor and Chief of Head and Neck Surgery Department of Otolaryngology - Head & Neck Surgery 550 Peachtree Street, Medical Office Tower, Suite 1135 Atlanta, Georgia 30308  
Fax: 404-778-2109 • Email: [meldeir@emory.edu](mailto:meldeir@emory.edu)

An Equal Opportunity / Affirmative Action Employer.  
Qualified minority and female applicants are encouraged to apply.

EOP # 34944BG

## Positions are available at the Assistant or Associate Professor level in the Department of Otolaryngology/Head & Neck Surgery



AUGUSTA UNIVERSITY  
**MEDICAL COLLEGE  
OF GEORGIA**

### HEAD AND NECK SURGEON

- VA Otolaryngology Division Chief
- Part-time appointment at Medical College of Georgia at Augusta University
- Rank commensurate with experience
- Excellent resources are available
- Fellowship training required
- Interest in reconstruction preferred

### NEUROTOLOGIST/OTOLOGIST

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

To apply and receive additional information, please contact:

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

Or email [skountakis@augusta.edu](mailto:skountakis@augusta.edu)

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



A well-established highly respected ENT private practice in Fayetteville,

### North Carolina

is seeking a full time BC/BE General Otolaryngologist, Otolologist or Facial Plastic Surgeon. Will also consider part time. We offer a full spectrum of ENT services including complete Audiology and Vestibular Services, Laryngology, Otology, Head and Neck Surgery, CT scanning, Hearing Aid Sales, Allergy, Balloon Sinuplasty, Eustachian Tuboplasty and LATERA implants.

The Fayetteville Sandhills region enjoys easy access to mountains and coastal beaches. We offer a competitive compensation package with potential buy in opportunity after 2 years of joining our practice.

For confidential consideration please email your CV to:

Dr. Steven Pantelakos at [stpent@nc.rr.com](mailto:stpent@nc.rr.com)

or

Gwendolyn Parks at [gparksfayent@ncrrbiz.com](mailto:gparksfayent@ncrrbiz.com)

*You may also visit us at [www.fayent.com](http://www.fayent.com)*



**Children's Mercy**  
KANSAS CITY

### Pediatric Otolaryngologist – Kansas City

Children's Mercy Kansas City is seeking a fellowship-trained pediatric otolaryngologist to join our professional staff at the assistant or associate professor level. We are specifically looking for an individual with a desire to dedicate their career to otology. This position will entail clinical care, research and education of medical students, pediatric and otolaryngology residents, and a pediatric otolaryngology fellow. The Section of Pediatric Otolaryngology at Children's Mercy operates in affiliation with the Department of Otolaryngology at the University of Kansas.

We currently have seven full-time and three part-time pediatric otolaryngologists on staff. We also have four part-time neurotologists on staff (who comprise approximately one full-time equivalent position). This new position offers an opportunity to take a leading role in the Children's Mercy Cochlear Implant Program.

Please send CV to [physicianjobs@cmh.edu](mailto:physicianjobs@cmh.edu)

Attention:

Robert A. Weatherly, MD

Division Director

[www.childrensmc.org](http://www.childrensmc.org)

## Join a growing team of clinical providers with the resources of one of the leading academic medical centers in the nation



**PennState Health**  
Milton S. Hershey  
Medical Center

Penn State Health Milton S. Hershey Medical Center is seeking candidates for our Division of Otolaryngology - Head and Neck Surgery within the Department of Surgery:

**Laryngologist:** We are seeking a full-time BC/BE Laryngologist. Appointment will be at the Assistant/Associate Professor level. Qualified candidates must have completed an approved residency program and be fellowship-trained to provide clinic and hospital-based laryngology care for patients. This will include treatment of the professional voice, endoscopic surgical procedures, voice restoration, and airway reconstruction.

**Pediatric Otolaryngologist:** We are seeking a full-time BC/BE Pediatric Otolaryngologist. Appointment will be at the Assistant/Associate Professor level. Qualified candidates must have completed an approved residency program and be fellowship-trained to provide clinical and hospital-based pediatric otolaryngology care to patients.

**General Otolaryngologist:** We are seeking a full-time BC/BE General Otolaryngologist. Appointment will be at the Assistant/Associate Professor level. Qualified candidates must have completed an approved residency program; extra subspecialization is encouraged, but not required.

**Apply online at <https://jobs.pennstatehershey.net>**

Penn State Health Milton S. Hershey Medical Center is a tertiary care facility that serves central Pennsylvania and northern Maryland. We are a part of a non-profit health organization that provides high-level patient services. Our campus includes a state-of-the-art, 551-bed medical center, a Children's Hospital, Cancer Center, research facilities, and outpatient office facilities. Penn State Hershey is the only Level I Trauma Center in Pennsylvania accredited for adult and pediatric patients.

Apply online at <https://jobs.pennstatehershey.net> or submit your current curriculum vitae to David Goldenberg, MD, FACS, Chief, Division of Otolaryngology - Head and Neck Surgery via email to [jburchill@pennstatehealth.psu.edu](mailto:jburchill@pennstatehealth.psu.edu).

*Equal Opportunity Employer. Minorities/Women/Veterans/Disabled.*

## 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 [aroten@ccoaa.com](mailto:aroten@ccoaa.com)*

## Otolaryngologist

### Expanding Practice in York, PA

A well established, busy four physician group in York, Pennsylvania is looking to add a fifth, full time Board Eligible/Board Certified Otolaryngologist. Our services include Allergy, Audiology and Hearing Aid Sales. Our office has been running on an EMR system since 2006. On-Call rotation is 1:5. Initial employment includes an excellent salary and productivity bonus. Partnership offered after 1 to 2 years of employment.

York is a fast growing community with excellent schools and a very comfortable cost of living. It is convenient to Baltimore, Washington and Philadelphia.

Local inpatient hospital is well run and state-of-the-art. Surgical Center is well equipped, and partnership in the Surgical Center is available.

We are looking for a dynamic, motivated individual for partnership track. Income potential in the 90th percentile.



**Contact: Renee Gohn**

**Office: 717-843-9089**

**Email: [yorkent@comcast.net](mailto:yorkent@comcast.net)**



## Neurotology Fellowship

The Neurotology Division at MUSC is seeking applicants for a two-year clinical fellowship position in Neurotology. Fellowship training includes all aspects of Neurotological and Otological surgery. The fellowship provides a wide variety of clinical and surgical opportunities including lateral skullbase surgery for removal of acoustic neuromas and other skullbase tumors, CSF leak repair, SCCD management, surgeries for malignancies involving the temporal bone, and other Neurotological procedures. In addition, we perform over 125 cochlear implants yearly. The fellow should be proficient with tympanoplasty, OCR and stapedectomy, and mastoidectomy and have a good working knowledge of cochlear implantation. The fellow is expected to assist in the supervision of some resident training in otologic procedures. In addition, the fellow covers attending Neurotology clinics. There is one fellow at a time for each two-year period. To date, we have graduated three fellows.

Four clinical faculty make up the Neurotology Division, Dr. Paul R. Lambert, Dr. Ted R. McRackan, Dr. Ted A. Meyer, and Dr. Habib G. Rizk. Dr. Rizk, our second fellow, directs the Vestibular program.

In addition, the division also boasts a tremendous research team under the direction of Dr. Judy R. Dubno. Numerous clinical and basic science research opportunities exist including the possibility of an additional year of research with T32 funding.

We have applied for ACGME accreditation for the Neurotology Fellowship. If ACGME approval is obtained next year, the 2018-2020 fellow would sit for the Neurotology Board.

Direct inquiries to:

**Ted A. Meyer, M.D., Ph.D.**

Associate Professor

Otolaryngology Residency Program Director

Neurotology Fellowship Program Director

Director - Cochlear Implant Program

Medical University of South Carolina

Department of Otolaryngology - Head & Neck Surgery

135 Rutledge Avenue, MSC 550

Charleston, SC 29425-0550

843-876-0112



### **Cape Cod Opportunity**

5-physician practice seeking general otolaryngology partner. Full service practice covering Cape Cod and Islands. Allergy, Audio, VNG, CO2 Laser, in-office Sinuplasty, Esophagoscopy, and video/strobe laryngoscopy. 1 in 6 call schedule.

Family friendly location close to Boston and Providence. Beautiful beaches, boating, fishing, golf, and other recreational activities. This area offers excellent school systems and the cultural diversity and amenities of the city in a beautiful family friendly environment.

Send CV to:  
Edward Caldwell, MD  
65 Cedar St Hyannis, MA 02601  
Or email [marieb@capecodent.com](mailto:marieb@capecodent.com)

### **THE UNIVERSITY of TENNESSEE** HEALTH SCIENCE CENTER

#### **Laryngologist (PIN 23075)**

The Department of Otolaryngology-Head and Neck Surgery, College of Medicine, University of Tennessee Health Science Center is seeking a candidate for an open-rank faculty position at the Assistant/Associate Professor level to join a growing and dynamic department. Rank is commensurate with education, credentials, and experience. Qualified individual must be Board Eligible/Certified and fellowship trained in Laryngology. 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](mailto: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.

### **General Otolaryngologist Clinical Instructor or Assistant Professor Anticipated Start Date: Summer-Fall 2018**

Department of Otolaryngology-Head & Neck Surgery, University of Michigan, Ann Arbor, Michigan

The Division of Laryngology and General Otolaryngology (LarGO) at the University of Michigan is seeking BC/BE general otolaryngologists to join the faculty of the Department of Otolaryngology-Head and Neck Surgery. Clinical responsibilities will be focused upon developing and growing a general otolaryngology practice. Individuals with or without fellowship training are encouraged to apply. In addition to outstanding clinical skills and drive, the successful applicant will have demonstrated potential to contribute to all missions of one of the largest and most outstanding clinical, teaching and research departments of otolaryngology in the country.

Interested applicants should submit a letter of interest, curriculum vitae and references to:

Traci L. Fletcher (email [traclyn@med.umich.edu](mailto:traclyn@med.umich.edu))  
Staff Specialist  
Department of Otolaryngology—Head and Neck Surgery  
1500 East Medical Center Drive  
1904 Taubman Center  
Ann Arbor, MI 48109-5312



### Academic Otolaryngologists

The Department of Otolaryngology is currently seeking to hire Academic Otolaryngologists with training and/or interest in Sinus Surgery or Head and Neck Oncologic Surgery or General Otolaryngology

The ideal candidates must have strong interest in academic career, a commitment to resident education and basic/clinical research as well as a desire to build a busy clinical practice. Academic appointment and compensation commensurate with training and experience. Candidates must be BC/BE in Otolaryngology.

Qualified and interested candidates should apply through WSU Online Hiring System at <https://jobs.wayne.edu> for

#### Posting # 042437 for Sinus Surgery, Head and Neck Oncologic Surgery or General Otolaryngology

Please also send letter of interest and CV to:  
Ho-Sheng Lin, M.D., Professor and Chairman  
Department of Otolaryngology  
4201 St. Antoine, 5E-UHC, Detroit, MI 48201  
[hlin@med.wayne.edu](mailto:hlin@med.wayne.edu)

Wayne State University is a premier, public, urban research university located in the heart of Detroit where students from all backgrounds are offered a rich, high quality education. Our deep rooted commitment to excellence, collaboration, integrity, diversity and inclusion creates exceptional educational opportunities preparing students for success in a diverse, global society. WSU encourages applications from women, people of color, and other under-represented people. WSU is an Equal Opportunity/Affirmative Action Employer.

### A highly respected well established ENT private practice in Fayetteville, North Carolina

Is seeking a Full Time BC/BE Otolaryngologist. Willing to consider part time. The practice is a busy physician owned and operated otolaryngology practice. It is a full service general otolaryngology clinic including a robust allergy department, two audiologists with a great hearing aids sales, and one physician assistant. Surgical cases include general head and neck surgeries, balloon sinuplasty, thyroid surgery, general otology and pediatrics.

Fayetteville is proud of its rich role in our nation's history and holds fast to the friendly feel of a true hometown, while providing the cultural and entertainment amenities of bigger cities. It has restaurants, museums, unique shopping, musical and sporting events, kid-friendly fun, elegant and quirky art galleries, gardens, trails and parks, not to mention nearby Fort Bragg that solidifies the city's deep roots in all things military. Greater Fayetteville is uniquely located to access all areas of North Carolina. It is a little over an hour from Research Triangle Park (RTP), Durham, Raleigh, and Chapel Hill, two hours from the beach, and three hours from the mountains.

A very competitive compensation package along with relocation assistance are offered. An opportunity after two years to buy in to the practice. Excellent interpersonal skills and motivation to help maintain a busy practice is a must.

Please submit a CV and cover letter to Eric Mansfield MD, MPH at [ericmansfieldnc@gmail.com](mailto:ericmansfieldnc@gmail.com) or [Ysmelser@capefearoto.com](mailto:Ysmelser@capefearoto.com)

Visit us at [capefearoto.com](http://capefearoto.com)

### Icahn School of Medicine at Mount Sinai • Department of Otolaryngology – Head and Neck Surgery

The **Mount Sinai Health System Department of Otolaryngology – Head and Neck Surgery** is seeking applications for full-time otolaryngologists to join the academic staff at the Icahn School of Medicine at Mount Sinai.

The Department offers candidates an outstanding opportunity to join our team of highly specialized otolaryngologists who practice in modern state-of-the-art facilities within the Mount Sinai Health System and in our satellite practices. The physician will provide the highest level of quality patient-centered healthcare and will embrace the teaching of medical students and residents, as well as participate in clinical research.

The candidate is required to have a medical degree, be board certified or board eligible and must be able to obtain a New York State medical license.

**The Department is seeking qualified otolaryngologists in all specialty areas.**

*Please send inquiries and curriculum vitae to:*

**Eric M. Genden, MD**  
Professor and Chairman,  
Icahn School of Medicine at Mount Sinai  
Department of Otolaryngology –  
Head and Neck Surgery  
One Gustave L. Levy Place  
Box 1189  
New York, NY 10029

Email:  
[kerry.feeney@mountsinai.org](mailto:kerry.feeney@mountsinai.org)





### **Current opportunities for a Head and Neck Physician, Laryngologist, and an Otolaryngologist, Head and Neck Surgeon with Allegheny Health Network.**

The Allegheny Health Network and Allegheny Clinic is located in Pittsburgh, PA. The new physicians will join a team of busy and successful ENT and Trauma Physicians and will be working within our City and Community hospitals. Applicants must be board certified or board-eligible.

The physician will be employed by the Allegheny Clinic of the Allegheny Health Network. Total compensation package will be commensurate with experience. Benefits include: medical, dental and vision insurance; life insurance; short term disability; long-term disability; flexible spending account; cash balance retirement plan; 401k retirement savings plan; 457(b) deferred compensation plan; paid vacation and CME allowance; paid sick days; paid holidays; possible relocation assistance, work-life balance program; day care center; fitness club; credit union; and paid bereavement days.

**The Allegheny Clinic, a part of Allegheny Health Network (AHN)** is an integrated network of primary and specialty care providers committed to achieving the highest level of patient satisfaction and clinical performance. Based in Pittsburgh, the organization includes over 900 physicians who practice in communities throughout Western Pennsylvania. Our physicians – along with a group of dedicated, compassionate nurses and support staff – provide a wide range of diagnostic, clinical and preventive services to patients of all ages.

**Allegheny Health Network (AHN)** – a subsidiary of Highmark Health, the third largest integrated health care delivery and financing system in the nation, – is an integrated delivery network focused on preserving health care choice and providing affordable, high-quality care to the people in our communities. With more than 14,000 employees including 7,400 health care professionals, and nearly 200 primary care and specialty care practices, Allegheny Health Network includes seven hospitals in Pennsylvania with nearly 2,400 licensed beds.

**Pittsburgh** is a vibrant and exciting city, offering a diversity of culture, world-class arts and music, state of the art health care systems, prestigious colleges and universities, a nationally praised culinary scene, home to major sports teams, making it one of the 'most livable cities' in the United States, as recognized by Forbes and The Economist. Pittsburgh's beautiful landscape, rivers and bridges, proximity to state and local recreational parks and affordable cost of living make it an attractive option for both individuals and families.

**Interested candidates please contact Ashley Fusco, Physician Recruiter, at [Ashley.Fusco@AHN.org](mailto:Ashley.Fusco@AHN.org)**



### **Full time Specialty and Sub-Specialty Positions Available At the Preeminent Otolaryngology Partnership in the Nation**

Here's your opportunity to become a member of ENT and Allergy Associates, LLP (ENTA) and serve patients in state-of-the-art clinical offices in **New York, the Hudson Valley, Long Island and New Jersey.**

**We have current openings in Midtown NYC, Bronx, White Plains, New Rochelle, Wayne, Somerset, Hauppauge, Port Jefferson, Southampton, Patchogue, Middletown and Rockville Center.**

#### **We offer new associates:**

- The collegial expertise and guidance of nationally and internationally recognized specialists and subspecialists
- The prestige of an academic institution, without the bureaucracy
- Clinical faculty appointments at renowned tertiary centers including Mount Sinai, Northwell and Montefiore
- A starting salary of \$300,000
- A well-traveled road to partnership without buy-ins and buy-outs
- A governance structure that gives you a voice from Day 1, and colleagues who understand there is more to life than just practicing medicine

#### **Our continued growth, coupled with upcoming physician retirements, means opportunity for you!**

For more information, contact our President, **Robert Green, MD** ([Rgreen@entandallergy.com](mailto:Rgreen@entandallergy.com)) or our Chief Executive Officer, **Robert Glazer** ([Rglazer@entandallergy.com](mailto:Rglazer@entandallergy.com) or call 914-490-8880).



The University of Utah, Department of Surgery, Division of Otolaryngology seeks a BC/BE Neurotologist at the Assistant Professor level for a full-time faculty position. Fellowship training is required.

Applicants must apply at:  
<http://utah.peopleadmin.com/postings/65281>  
 and send a list of three references to:

**Clough Shelton, MD, FACS, Professor and Chief**

University of Utah School of Medicine  
 50 North Medical Drive 3C120  
 Salt Lake City, Utah 84132  
 (801) 585-3186  
[susan.harrison@hsc.utah.edu](mailto:susan.harrison@hsc.utah.edu)

The University of Utah Health (U of U Health) is a patient focused center distinguished by collaboration, excellence, leadership, and respect. The U of U Health values candidates who are committed to fostering and furthering the culture of compassion, collaboration, innovation, accountability, diversity, integrity, quality, and trust that is integral to our mission.

**Equal Employment Opportunity**

University of Utah is an Affirmative Action/Equal Opportunity employer and does not discriminate based upon race, national origin, color, religion, sex, age, sexual orientation, gender identity/expression, disability, status as a Protected Veteran. Upon request, reasonable accommodations in the application process will be provided to individuals with disabilities. Inquire about the University's nondiscrimination policy or request disability accommodation, please contact: Director, Office of Equal Opportunity and Affirmative Action, 201 Presidents Circle, 135, (801)581-8365.

**Academically Oriented General Otolaryngologist – Philadelphia**

Join an academic department with a unique private practice component. Anticipate starting as Instructor or Assistant Professor (Assistant Professor requires board certification), or at a higher academic rank as appropriate.

Master's Degree, area of subspecialty interest or fellowship preferred but not essential. Subspecialty interest in Rhinology, Allergy, and/or Sleep Medicine and other areas (including endocrine and/or head and neck surgery) would be welcome, but not required. Clinical excellence, collegiality, dedication, and commitment to teaching are essential. Writing and research (clinical or basic) are encouraged, and mentorship is available within the department.

Clinically, the position involves all areas of General Otolaryngology, although most Otolaryngology and Laryngology are done by subspecialists within the department. There is a good opportunity for endocrine and head and neck cancer activity, but neither is essential.

In addition to clinical practice and shared coverage (evenings and weekends), participation within the university community through committee memberships and other activities is encouraged; and regional and national activity also is encouraged.

Interested applicants may contact Robert T. Sataloff, MD, DMA, FACS, Professor and Chairman, Department of Otolaryngology-Head & Neck Surgery, Senior Associate Dean for Clinical Academic Specialties, Drexel University College of Medicine, 219 N. Broad Street, 10th Floor, Philadelphia, PA 19107, [rtsataloff@phillyent.com](mailto:rtsataloff@phillyent.com).

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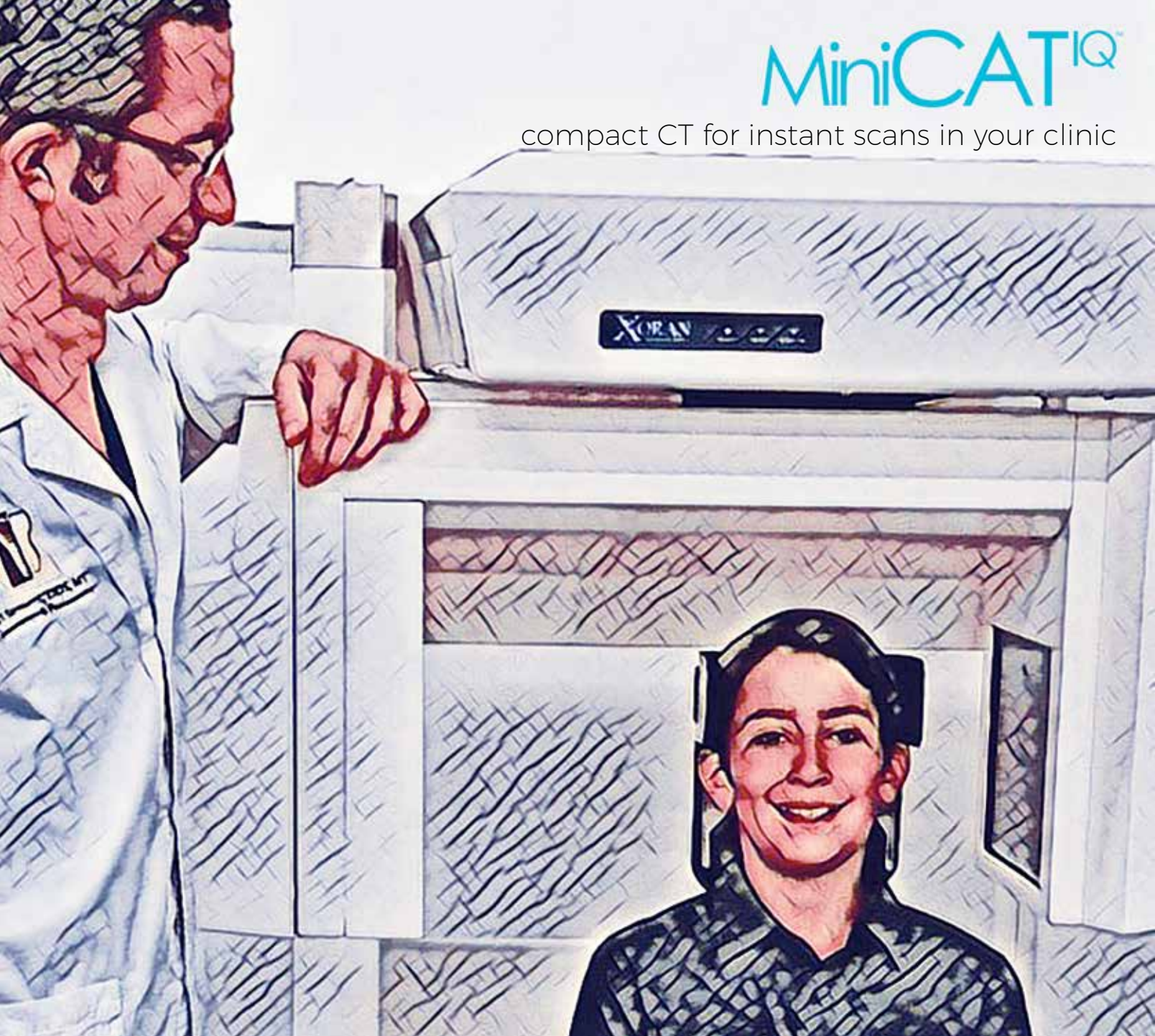
William E. Davis Professor and Chair  
 Department of Otolaryngology—Head and Neck Surgery  
 University of Missouri—School of Medicine  
 One Hospital Dr MA314 DC027.00  
 Columbia, MO 65212  
[zitschr@health.missouri.edu](mailto:zitschr@health.missouri.edu)

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