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NOVEMBER 2019

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A unified approach to patient care

I am still riding the wave of excitement and energy that accompanied our recent Annual Meeting in New Orleans, starting with an unforgettable Welcome Ceremony and President's Reception, led by **Albert L. Merati, MD,** Immediate Past President. I am told we set attendance records for an AAO-HNSF Annual Meeting, which provided ample opportunities and access to scientific education (hands-on, interactive, and didactic), networking, work/career information/interviews, practice management, medical products/services, and equipment at the OTO Experience, and included attendees from across the globe.

Our location in "the Big Easy" did not disappoint, as we all probably picked up a few pounds with some of the best possibilities for our palates. However, this was not without a balance of the wellness offerings that included OTOs on the Run 5K, sunrise yoga, and talks centered on staying healthy and avoiding burnout. Our many honorary guest lecturers, who included **Dana M. Thompson, MD, MS; Rahul K. Shah, MD, MBA; Andrea Vambutas, MD; Baran D. Sumer, MD;** and **Professor Hisham Mehanna, PhD, MBChB, FRCS, FRCS (ORL-HNS),** were insightful, thought-provoking, educational, and, most importantly, memorable. They certainly all paid sufficient tribute to the individuals for whom these lectures were named.

Finally, the Academy's presence in the city brought with it a spirit of giving back as the William Harry Barnes Society hosted a lunch for undergraduate premed students at Xavier University to share the experiences and fulfillment of our specialty. Thanks to our incredible staff for their hard work and thanks to you for your attendance.

As I mentioned in my previous column, one of the areas I would like to focus on during my term as President is helping our patients to become more involved in their care. We are faced daily with the dilemma of how we as specialists can effectively assist in this process when we already have forces such as EMR documentation, MIPS, and prior authorizations competing for a significant portion of our time and that of our staff. Many of us associate the concept of patient-centered care with the primary care physician—and much of it does fall within the primary care provider's purview. However, our understanding of this is essential in helping to assure our patient compliance.

The Institute of Medicine defines providing patient-centered care as providing "care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide clinical decisions." In research conducted by Picker Institute and Harvard Medical School, there are eight principles of patient-centered care that include:

1. Respect for patient preferences
2. Coordination and integration of care
3. Information and education
4. Physical comfort
5. Emotional support
6. Involvement of family and friends
7. Continuity and transition
8. Access to care

I realize that there will be divergence of opinion on how much we as physicians should be allowing patients to guide their own care; however, it is truly a partnership if we strive to achieve the best outcomes. These eight principles, along with health literacy and cultural competency, are ones that—if considered and addressed—can only help to assist us with having happier, healthier, and more knowledgeable patients with successful treatments.

We are in an age now where we must find a balance of how we can maximize digital technology, discussions with our primary care colleagues, patient portals, practice websites, waiting room information, and now the AAO-HNSF website **ENThealth.org**, to empower our patients to proactively partner in their care. I see patient involvement with their care—complemented by the right knowledge that we provide (in a variety of ways)— as an opportunity that may enable us to better serve our patients. ■

Duane J. Taylor, MD
AAO-HNS/F President

“I see patient involvement with their care—complemented by the right knowledge that we provide (in a variety of ways)— as an opportunity that may enable us to better serve our patients.”

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#AAFPRSRhino2020

The Annual Meeting and beyond

I recently attended my 38th Annual Meeting of the AAO-HNSF. There was a great deal of energy and excitement at our meeting in New Orleans as well as the specialty society meetings taking place in conjunction with the Annual Meeting. It was encouraging to see the collaboration and camaraderie displayed across the breadth of attendees as they interacted in the hallways, throughout the lectures, and at the recreational activities. There was a measurable increase in attendance over our last two meetings in Atlanta and Chicago, which added to the buzz around the convention center. Domestic and international attendees benefited from enhanced networking time and took full advantage of the opportunity. This year's attendees represented all 50 states and 94 countries worldwide.

The diversity of our specialty was on full display in the subject matter and experts presenting the comprehensive education program, which was crafted by **Mark K. Wax, MD;** the Annual Meeting Program Committee; the many committee and section meetings that convened; and the ancillary alumni and society gatherings in the evening across the city. While each of these groups has specific interests, it is encouraging to see them all move together in the true "We Are One" mission of our specialty. The large number of residents, fellows, and young physicians, both domestic and international, bodes well for the future of our Academy and our specialty. It is incumbent on us to maintain the momentum created at this meeting as our committees and task forces work with our staff to move the specialty forward in the direction we want to go, always striving to improve patient care. A special shout-out goes to all our volunteer leaders, participants, and dedicated staff who made this exhilarating meeting possible.

At the Foundation Board of Directors meeting, our clinical data registry, Reg-ent[SM], reached another milestone. The directors approved a Letter of Agreement with OM1 to become our partner in moving Reg-ent forward to Phase II and beyond. This agreement will help us optimize our data through normalization, curation, and validation using the OM1 process that will make the data suitable to drive a number of advanced functions beyond the public MIPS reporting currently taking place. This gives us the opportunity to define "best care" for diseases otolaryngologists treat, participate in academic clinical research to the degree not previously possible, conduct pre- and post-market device and pharmaceutical trials meeting FDA standards, and begin the journey toward individualized patient care. If you are not currently a member, now is the time for both academic and private practices to join and become part of this vehicle that will drive improved patient care for all.

Our global program continues to expand in breadth, volume, and quality. This year in New Orleans, there were over 1,700 international attendees from around the globe. The International Symposium covered three days and had over 50 presentations that were attended by both domestic and international physicians. The International Advisory Board (IAB) held its second election for Chair of the IAB. I would like to congratulate, **Karl Hoermann, MD,** on his election. He will take office in 2020, following current Chair, **Sady de Costa, MD**. It is exciting to see the accelerating degree of scientific exchange around the globe as we all try to optimize patient care. An equal part of this equation revolves around our joint meetings with international societies in which we send faculty to participate and exchange clinical expertise with their colleagues. The AAO-HNSF will participate in 15 joint meetings this year and already has 10 scheduled for 2020, and I, along with **J. Pablo Stolovitsky, MD,** AAO-HNSF Coordinator for International Affairs, attended the annual meeting of the Chinese Society of Otolaryngology in October to explore ways we can collaborate on a variety of educational initiatives. I encourage you to join the team and become an international volunteer faculty member.

We welcome **Duane J. Taylor, MD,** as our new President for 2019-2020. Dr. Taylor is the first African American President of the AAO-HNS/F. He is a fellowship-trained facial plastic surgeon who practices general otolaryngology in the Washington, DC, area. He brings considerable experience in physician wellness and was the inaugural Chair of the Diversity and Inclusion Committee that I formed when I was President in 2008. The Boards of Directors, the entire staff, and I look forward to working with Dr. Taylor throughout the upcoming year. ■

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

> "It is incumbent on us to maintain the momentum created at this meeting as our committees and task forces work with our staff to move the specialty forward in the direction we want to go, always striving to improve patient care."

at the forefront

Information, resources, and updates in this section

READ MORE ONLINE

From simulations to real patients: Humanitarian work in Vietnam

FDA grants first-ever modified risk orders to eight smokeless tobacco products

Even as citizens of the United States deal with previously unrecognized significant dangers related to vaping of many substances and aggressive marketing of Juul-type products, the FDA, on October 22, 2019, for the first time authorized the marketing of products through the modified risk of tobacco product (MRTP) pathway outlined in the 2009 Family Smoking Prevention and Tobacco Control Act.

This action authorizes the manufacturer to market these products with the following claim, "Using General Snus instead of cigarettes puts you at a lower risk of mouth cancer, heart disease, lung cancer, stroke, emphysema, and chronic bronchitis." The ruling limits marketing to adults, and the FDA placed stringent advertising and promotion restrictions on the products. This ruling affects eight products, and the modified risk orders are product-specific and limited to five years.

The FDA rightfully states, "All tobacco products are potentially harmful and addictive, and those who do not use tobacco products should continue to refrain from their use." Unfortunately, while the packaging must also include the warning statements required for all smokeless tobacco products, those reading the package warning will not have access to the FDA's full press release and will miss the message that no tobacco product has any positive health benefit.

The AAO-HNS **opposes** support of snus or any other tobacco or vaping product. This has significant potential to increase tobacco usage in the youth population as well as adults and give first-time users an unwarranted feeling of security in using these flavored tobacco products. **We urge repeal of this MRTP for snus products.**

Read the full release from the FDA at https://www.fda.gov/news-events/press-announcements/fda-grants-first-ever-modified-risk-orders-eight-smokeless-tobacco-products ■

Senator talks surprise billing

The AAO-HNS was pleased to host U.S. Senator Bill Cassidy, MD (R-LA) as the guest speaker at an Advocacy Breakfast during the AAO-HNSF 2019 Annual Meeting & OTO Experience on September 16 in New Orleans. Dr. Cassidy, the state's senior senator, has been a strong ally for the physician community and a bold leader on healthcare issues impacting the house of medicine. He shared his thoughts on the growing debate surrounding remedies for surprise medical bills and drug pricing reforms. Senator Cassidy also provided his perspective on the need for increased transparency in our healthcare system. The Academy continues to work with Senator Cassidy and other Congressional champions on a sensible solution to surprise billing, as well as audiology direct access legislation and other important issues being debated in Congress. ■

Senator Bill Cassidy (R-LA) (center), pictured with Carol R. Bradford, MD, MS, AAO-HNS/F President-Elect, and Gavin Setzen, MD, AAO-HNS/F Past President.

Call for 2020 AAO-HNS election nominees

The Nominating Committee is calling for recommendations for individuals to be considered for an AAO-HNS elective office. To qualify, an Academy member must be in good standing, 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 and submit the application materials to a Nominating Committee member, requesting their support for your nomination to elected office. The application deadline is midnight (ET) on December 2. ■

Learn more: **https://www.entnet.org/content/call-2020-election-nominees**

SRF SECTION FOR RESIDENTS AND FELLOWS-IN-TRAINING

The trainee's quick guide to AAO-HNS/F funding

■ **Kevin Zhan, MD,** SRF Information Officer

The freshly minted ENT intern with the unharmed pager, mired in the concerns of how to replete potassium, spray a nose, or even look at a temporal bone, may be joyfully aloof to Academy funding opportunities. And as the responsibilities accumulate with increasing PGY years, Academy awards can turn out to be an enormous missed opportunity. Fortunately, the Academy's Section for Residents and Fellows-in-Training (SRF) prioritizes keeping all trainees abreast of all funding opportunities. Every resident and fellow paying Academy membership dues is an SRF member and eligible for funding, regardless of PGY year or country, and every trainee should apply for funding.

Resident Leadership Grants and Humanitarian Travel Grants

Approximately 90 travel grants are biannually given to help finance travel to the AAO-HNSF Annual Meeting & OTO Experience and the AAO-HNS/F Leadership Forum & Board of Governors (BOG) Spring Meeting. Academy involvement, such as being a committee member, delegate to other societies, SRF residency representative, or part of the SRF Governing Council, improves the chances of receiving these awards. A leadership primer is available on the SRF webpage **(https://www.entnet.org/content/section-residents-and-fellows-training).** The Humanitarian Travel Grants fund trainees participating in medical missions and are awarded twice a year. Recipients of these competitive humanitarian awards must publish a report of their experience in the *Bulletin.*

Academy CORE Grants

These grants are prestigious research awards ranging from $5,000 to $150,000 with funding from the AAO-HNSF, specialty societies, and industry sponsors. Letters of Intent are due December 16, with full grants due January 15. These competitive grants are awarded the following June. Visit **www.entnet.org/core.**

Eisenberg Health Policy Resident Leadership Grant

This grant annually funds three to four leadership-minded trainees to attend the Leadership Forum & BOG Spring Meeting and advocate for our specialty with the BOG leadership to members of Congress. Awardees experience a unique leadership opportunity and participate in significant ENT advocacy and lobbying efforts.

As shown, the Academy provides a wealth of funding opportunities for trainees at every stage, every year, for all walks and interests and always seeking other support methods. The SRF is eagerly available to help navigate these opportunities **(srf@entnet.org).** ■

"The Eisenberg Grant gave me the opportunity to meet leaders in otolaryngology and participate in all types of discussions ranging from diversity to physician burnout. I was able to learn a great deal and attend briefings on hot topics such as the future of healthcare policies and changing regulations, which will impact my future practice and the welfare of my patients."
Zahrah Taufique, MD | New York University School of Medicine

"The opportunity to meet the leaders in our field who are passionate about improving patient care and learn about issues facing our current and future practice was truly unique. I feel incredibly fortunate that I was selected for this award, and would encourage anyone with an interest in leadership and advocacy to apply for it."
Susannah Orzell, MD, MPH | SUNY Upstate Medical Center

AAO-HNS/F COMMITTEES

Pathway to leadership: Apply today!

Apply to become an AAO-HNS/F committee member, and let your voice be heard! The 2020-2021 application cycle is now open and will close on January 1. All committee applicants should be in good standing with the Academy and must be a fellow, member, resident member, scientific fellow, international fellow, or international member of the Academy to be eligible to serve as a committee member. For questions, contact committees@entnet.org.
https://www.entnet.org/content/committees ■

OTOSOURCE COMPREHENSIVE OTOLARYNGOLOGY CURRICULUM

With OTOSource.org now completed, residents, program directors, faculty members, and practicing otolaryngologists can use this free, comprehensive online study guide while seamlessly accessing topical education activities in AcademyU or the Otolaryngology Specialty Society. Explore the 11 units available by going to https://www.otosource.org/. ■

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DON'T MISS THE LATEST PODCAST FROM OTO JOURNAL

Rethinking Malignancy Risk in Indeterminate Thyroid Nodules with Positive Molecular Studies: Southern California Permanente Experience

Visit *Otolaryngology-Head and Neck Surgery* at **http://sageotolaryngology.sage-publications.libsynpro.com/** to listen.

INTERNATIONAL VISITING SCHOLARSHIP REPORT

Meet Professor Titus Sunday Ibekwe, MBBS, FWACS

I am **Titus Sunday Ibekwe, MBBS, FWACS,** Professor and Head of the Department of Otorhinolaryngology (ORL) at the University of Abuja and University of Abuja Teaching Hospital in Nigeria. I most recently served as Vice Chair to the International Advisory Board of the AAO-HNSF. My interest in otorhinolaryngology was partly circumstantial and also out of admiration for ORL. I suffered from recurrent tonsillitis in childhood through adolescent life, had a tonsillectomy in my final year of medical school, and scored very high in ORL assessments/examinations. As a result, I made up my mind to become an otorhinolaryngologist while still a medical student.

Q What motivated you to apply for an International Visiting Scholarship from the AAO-HNSF?

The search for knowledge brought me close to my teacher and mentor, **Prof. Onyekwere George Nwaorgu, MD, FWACS,** during my residency days. We wrote several research papers together and attended conferences within Nigeria and Africa. He encouraged me to apply for the AAO-HNSF International Visiting Scholarship (IVS), which I was awarded in 2009.

The award of the IVS marked my maiden attendance of AAO-HNSF Annual Meeting & OTO Experience in San Diego, California, after which I went to the New York Presbyterian Hospital and Cornell University in New York for tutelage under **Michael G. Stewart, MD, MPH,** and Samuel Selesnick, MD. I also got an offer to visit the head office of Starkey Hearing Foundation in Minnesota for training in audiology. I met Brian D. Westerberg, MD, and **Frederick K. Kozak, MD,** who arranged a hands-on fellowship in otology at the University of British Columbia in Vancouver, Canada, for me. These were turning points and catalysts to my career.

Q What value and benefit did you obtain for you and your practice by attending the AAO-HNSF Annual Meeting & OTO Experience?

The Annual Meeting has been a "melting pot" for connections with first-class otorhinolaryngologists and exposure to the latest innovations in the field of ORL globally. I am proud to have attended these meetings for the past decade and still counting.

Q Please share your experience during your observership, such as where it was and what was your area of focus?

My observership in the New York Presbyterian Hospital was a great career boost in both clinical and research practice of ORL. My hosts were great teachers and friends with whom I maintain a good relationship. It was an opportunity to see what is being done in the developed world in comparison with resource-limited countries. My focus was in otology and audiology, though I also observed what was obtainable in other subspecialties. There was knowledge sharing, hence I made presentations on rare illnesses that were hardly encountered in the United States, such as sensorineural hearing loss resulting from Lassa fever infections.

Q What would you say to encourage others to donate to the AAO-HNS *foundation?*

The execution of this project and its sustenance is capital intensive and therefore takes a lot of commitment from the AAO-HNS/F. There is also the need to increase the number of spots to accommodate many young ENT surgeons. This can only be possible through the collaboration of development/funding partners, nongovernmental organizations, and public-spirited individuals with the AAO-HNS. I strongly recommend that these groups consider endowment to the IVS program, as this will help in training astute physicians capable of training others in the various climes. ■

AAO-HNSF Future of Education

Richard V. Smith, MD, outgoing Coordinator for Education, and **Jeffrey P. Simons, MD,** incoming Coordinator for Education, share their vision for the future of the AAO-HNSF offerings in this interview captured at the AAO-HNSF 2019 Annual Meeting & OTO Experience in New Orleans, LA. http://entnet.libsyn.com/aao-hnsf-future-of-education ■

HUMANITARIAN GRANT

From simulations to real patients: Humanitarian work in Vietnam

Sarah E. Hodge, MD, traveled to Hanoi, Vietnam, to work and learn at the National ENT Hospital, which is the largest referral center in the northern half of Vietnam. Hodge worked alongside other otolaryngologists from the United States and Vietnam as well as the Resource Exchange International – Vietnam, an international not-for-profit organization that has been working in Vietnam since 1992.

In addition to an education conference, "Updates in Otolaryngology," Dr. Hodge was able to participate in simulated skills labs and to perform a range of surgeries, from tonsillectomies to skull base tumor resections with local flap reconstruction. ■

#OTOMTG19 Where Experts and Science Converged in New Orleans

There was a global connection of the specialty, unified by expert presenters and the latest research, covering 11 specialty areas via 10 groundbreaking education program formats. There was more than an acre and a half of vendors with emerging technologies, devices, and resources for patient care. There were networking opportunities that provided camaraderie and connection. There was a President's Reception that some attendees dubbed as "the best ever" with food, fun, music, and dancing. It was the AAO-HNSF 2019 Annual Meeting & OTO Experience and it was indeed "Where Experts and Science Converge"—and so much more.

During the Welcome Ceremony remarks, **Albert L. Merati, MD,** the 2018-2019 AAO-HNS/F President, offered inspiration to the broad, diverse audience. "We have a responsibility to each other and our patients to stand together, to fight together, to think together as we further the day-to-day miracle of surgery—improving lives and communities with our skill and knowledge."

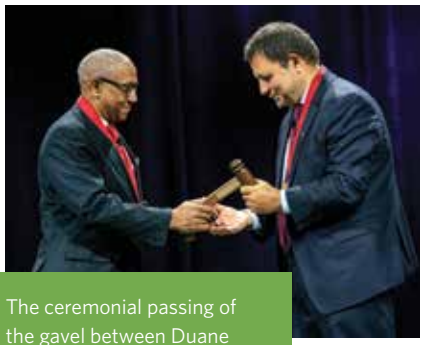
This message of togetherness and "We Are One" resonated throughout the ceremony and in the days that ensued. It was a meeting of opportunity with over 7,500 attendees—every continent was represented with individuals from 94 countries. Attendees discovered the latest advancements and research in the specialty through a dynamic education program developed by the Annual Meeting Program Committee led by **Mark K. Wax, MD.** The program offered abounding opportunities, featuring 261 Expert Series Sessions, 134 Panel Presentations, 591 Poster Presentations, 340 Scientific Orals Presentations, 24 Master of Surgery Videos, and 53 International Symposium sessions.

The opportunities and education expanded to the OTO Experience, which featured a comprehensive display of products and services, including mobile X-ray imaging, enhanced surgical tools, regenerative medicine solutions, and more. Attendees experienced hands-on learning in the Mobile BioSkills Lab and the Hands-on Demonstration and Training Lab, innovative technology in the new Emerging Tech Pavilion, and new procedures and services in the Product Theater.

This Annual Meeting also exuded a global presence, further epitomizing the "We Are One" sentiment. This strength of unity and togetherness was specifically noted by **James C. Denneny III, MD,** AAO-HNS/F EVP/CEO, "Our global program has continued to flourish under the leadership of Dr. Pablo Stolovitsky and our entire global team. In 2019 we will have participated in 15 joint meetings… and the International Symposium has over 50 presentations."

For 2019, the International Symposium showcased cutting-edge content presented by international physicians. It provided a global perspective of popular topics in otolaryngology and also included an International Young Physicians Meet & Greet and Forum; the International Women's Caucus with a panel presentation titled, "Negotiating Your Way Past Barriers: International Women in Otolaryngology;" the Humanitarian Efforts Forum; and the International Advisory Board (IAB) General Assembly, in which **Karl Hoermann, MD,** from Germany, was elected Chair-Elect. ■

At the close of the Welcome Ceremony, attendees joined in a traditional New Orleans Second Line and followed a brass band to the buses for a short ride to the President's Reception at Mardi Gras World, where the famous floats are made. At the President's Reception, attendees were welcomed with New Orleans cuisine, fun, and the sounds of Rockin' Dopsie, Jr. and the Zydeco Twisters.



The ceremonial passing of the gavel between Duane J. Taylor, MD, and Albert L. Merati, MD, during the Welcome Ceremony.

During the International Advisory Board General Assembly, it was a rare moment to capture all the individuals who have served as AAO-HNSF Coordinator for International Affairs to date. From left to right are Eugene N. Myers, MD, FRCS Edin (Hon), K J Lee, MD, Gregory W. Randolph, MD, James E. Saunders, MD, J. Pablo Stolovitzky, MD.

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Annual Meeting Webcasts

Did you attend **#OTOMTG19** as a "Full Conference" registrant? If so, your education opportunities didn't end when you departed New Orleans, LA. With your registration, you receive unlimited access to all 2019 recorded education sessions through AcademyU for three years. To access the webcasts, go to http://academyu.entnet.org and click on the Annual Meeting Webcast icon.

AAO-HNSF 2020 ANNUAL MEETING & OTO EXPERIENCE

BOSTON

SEPTEMBER 13-16

BRINGING TOGETHER *the* WORLD *of* OTOLARYNGOLOGY

As the 2019 Annual Meeting came to a close, the #OTOMTG19 euphoria filled the air, lifting attendees up and away, and looking forward to the AAO-HNSF 2020 Annual Meeting & OTO Experience in Boston, MA, September 13-16. "Bringing Together the World of Otolaryngology" will be a program with unlimited potential and countless opportunities for attendees both as individuals and as collective members of this global specialty—all in the name of patient care.

#OTOMTG20 Call for Science

November 18, 2019 - January 14, 2020

Learn more at **www.entannualmeeting.org**

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- Your profile listed on "Find an ENT" on ENThealth.org, the Foundation's interactive patient information website (practicing physicians only)
- Member-only registration discount for the AAO-HNSF Annual Meeting & OTO Experience – full conference attendees receive unlimited online access to all recorded education sessions through AcademyU®
- Subscriptions to the peer-reviewed scientific journal, *Otolaryngology–Head and Neck Surgery,* and the *Bulletin*, the official magazine of the AAO-HNS
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Five **more** questions to ask your administrator

* Part one of this series can be found in the August 2019 *Bulletin,* page 9.

https://bulletin.entnet.org/article/five-questions-to-ask-your-administrator/

You can't be everywhere in your practice at once. Therefore, you need to rely on your administrator to run your business. You can stay apprised by asking them some standard questions. We started with five questions a few months ago, and here are five more.

1. How many days in accounts receivable (A/R) do we have?

A/R measures how quickly a practice can get paid. The formula for calculating A/R days is as follows:

- Number of days in A/R equals the current net receivables balance divided by the average daily charge amount (A/R days = A/R balance/average daily charge amount).
- The A/R balance reflects the total amount of outstanding accounts receivables.
- The average daily charge amount is calculated by taking the total gross charges for the last year divided by 365 days.

Low A/R indicates that the practice is filing insurance and getting paid quickly. It is important to know what it is over time. For example, if you are normally in the 30-to-35-day range and it starts to increase to 60 days, it needs to be investigated. Is it one payer? Are claims not being submitted in a timely manner? Is there an underlying issue causing the lag? Your administrator should know where to start looking, be able to state the issue, and explain how they are working to resolve it.

2. What is our overhead rate?

Simply put, this is a percentage of expenses over revenue. However, all practices don't calculate this the same. The calculation for overhead percentage is expenses divided by revenue multiplied by 100 (% = expenses/revenue X 100).

When you hear at meetings, or in the surgeon's lounge at the hospital, that another practice's overhead is 11 percent and yours is 68 percent, it is highly likely that you aren't comparing apples to apples. Make sure you and your administrator know what is included in your overhead calculation and what isn't. For example, one practice could include all practitioners and others may exclude advanced practice providers. The same goes with other practice expenses. Some practices include all expenses, while others may only include selected expenses.

3. What is our payer mix?

You should always know who is paying you and the percentage of revenue coming from that source. The calculation for payer mix percentage is amount of revenue from a particular payer divided by total revenue multiplied by 100 (% = revenue from payer/total revenue X 100).

You should track this over time. Through your contracts with insurance companies, the same procedure can be reimbursed at different rates and speeds. Your cash flow could be affected if you have a large group of private insurers and start shifting toward government payers or even self-pays. If you have a large percentage of Medicare patients, you might want to market to the largest private insurer in town for patients to improve the payer mix.

4. Tell me about my experience as a new patient in the practice.

Listen to your administrator explain what happens from the time the phone is answered for an appointment until the time a patient sees the physician. Is this the experience that you want to deliver to the patient? If not, what are the "pain points" that need to be addressed? Open the dialogue on what your vision of the experience should be with your administrator. Decide on what opportunities your practice should focus on to improve the experience for the patient.

5. Do you belong to ASCENT?

If not, why? ASCENT is a community created to empower the manager, administrator, and practice. It is composed of 1,000 managers, CEOs, administrators, and more doing the same daily things that your practice leader is doing. We have resources your manager needs so he/she doesn't have to create procedures, policies, etc., from scratch. If your administrator tells you he/she is too busy to join, your response should be you are too busy NOT to be a part of this network.

Our discussion boards bring daily practice situations to members' attention and, 95 percent of the time, someone has dealt with an issue you're experiencing and can offer advice. Still not convinced? Maybe your manager is content to be doing the same things they did 10 years ago. However, practices have changed at a rapid rate, and everyone needs as much help as they can get to keep their practice in good health. Ask your manager to join today: **askASCENT.org/join.** ■

ASCENT, formerly the Association of Otolaryngology Administrators (AOA), is a support community and resource network for ENT practice management leaders. The community consists of invaluable resources, education, and people to enhance the quality and sustainability of the ENT practice. Representing more than 1,000 professionals across the country, ASCENT enables ENT leaders to advance their practices in the business of medicine. Learn more about our new look at www.askASCENT.org/OurStory.

Q&A with the ASPO leadership

AMERICAN SOCIETY OF PEDIATRIC OTOLARYNGOLOGY

Anna H. Messner, MD
ASPO President

Reza Rahbar, DMD, MD
ASPO Secretary

What are the most pressing issues facing pediatric otolaryngology, both domestically and globally?

1. Access to quality pediatric otolaryngology care for all children
2. Standardization of training for otolaryngologists in the field of pediatric otolaryngology

What are some of the barriers to optimal care for infants and children, and how can we eliminate them?

The number one barrier is lack of access to care. Nationally, the access issue can be due to a lack of locally available practitioners or pediatric-appropriate surgical facilities (including pediatric anesthesia), and, in the immigrant population, parental fear of visiting healthcare facilities. ASPO is partnering with national societies such as the American Academy of Pediatrics and the American College of Surgeons to promote programs providing otolaryngologic care to children. Internationally, ASPO works with other pediatric otolaryngology organizations, like the European Society of Pediatric Otolaryngology and the Interamerican Association of Pediatric Otorhinolaryngology, to promote pediatric otolaryngology education.

What are some key advancements in research and treatment in pediatric otolaryngology, and how has that impacted the specialty and the patients?

In recent years, newborn screening tests for congenital cytomegalovirus and cystic fibrosis have become routine in many areas. Early identification of these disorders leads to better care and improved long-term outcomes.

The AAO-HNSF promotes a Kids Safe Holiday this time of year. Does ASPO have any similar recommendations or resources to educate the public?

This a website in both English and Spanish aimed toward families regarding the risks of button batteries: **https://www.healthychildren.org/English/safety-prevention/at-home/Pages/Button-Battery-Injuries-in-Children-A-Growing-Risk.aspx.**

Of all the priorities of ASPO right now, which one or two would you want to impress upon your colleagues practicing in all subspecialty areas as essential to the work, mission, and vision of ASPO?

Providing the highest level of care and providing access to all. ■

ASPO: What you should know about our society

Our mission is to foster excellence in the care of children with otolaryngologic disorders by promoting education and collaborative research and to share and disseminate advances and innovations in patient care through the Annual Meeting and other venues.

Membership:

- Total membership: 641 with steady growth and increasing diversity

Endowment:

- Sound financial structure due to close monitoring of operating cost and endowment
- Active Development Committee with close interaction with our members to determine what initiatives can most benefit from ongoing support

Research and education:

- Funded 41 new projects (since 2005) with total financial support of close to $700,000 to push our specialty into new frontiers and to provide useful information for our pediatric and general ORL colleagues

Meeting and conferences:

- Annual Spring Meeting held in conjunction with Combined Otolaryngology Spring Meetings (COSM) with one of the highest number of attendees at the COSM for the past decade. (Once every four years, ASPO rotates out of COSM and holds a breakout meeting, happening next in Montreal in 2021.)
- ASPO Summer Meeting (Frontiers in Pediatric Otolaryngology), which is in its fourth year and takes place in Vail, CO
- Free annual Resident/Fellow Seminar in conjunction with AAO-HNS, most recently in New Orleans

For more information about ASPO, becoming a member, research and education initiatives, and future meetings, please visit **http://aspo.us/.** ■

OTO Journal

Building a world of expert peer reviewers: Resident Reviewer Development Program

By Jennifer J. Shin, MD, SM

Otolaryngology-Head and Neck Surgery invites residents to apply to enroll in the Resident Reviewer Development Program.

The Resident Reviewer Development Program pairs qualified residents with seasoned peer reviewers to foster the growth and development of the next generation of otolaryngology peer reviewers. Residents typically complete three to six mentored reviews and, when recommended by their mentor, perform a proposed independent review. Graduates of the program join the main reviewer pool for the journal. Excelling as a peer reviewer is often the first step toward becoming a Star Reviewer, Editorial Board member, or Associate Editor.

The program has grown, with the largest resident class to date enrolled in 2019. Thirty-five graduates of the program maintained an average rating of excellent, and six achieved Star Reviewer status. We also saw the inaugural international graduate of the program in 2018, and the first European matriculant in 2019. International applicants are encouraged.

We at *Otolaryngology-Head and Neck Surgery* look forward to the next cohort of successful graduates. ■

Mentors and mentees enjoy camaraderie and expressions of gratitude at the Resident Reviewer Development Program Reception during the AAO-HNSF 2019 Annual Meeting & OTO Experience.

To be considered for the 2020 class, applications should be submitted by January 13, 2020.

Prerequisites

Applicants should:

- Be PGY-3 or PGY-4
- Have their department chair sign the Letter of Support
- Submit the Resident Reviewer Application Form
- Professional working proficiency or full professional proficiency in English

To learn more, please visit the Resident Reviewer Development Program page. **https://www.editorialmanager.com/otohns/accounts/ReviewerPage.html#resident**

If you are an experienced peer reviewer and are interested in serving as a mentor for the program, please contact the journal office at **Otomanager@entnet.org.** We also welcome communication from residency program directors regarding interest in the program. ■

Richard M. Rosenfeld, MD, MPH, MBA
5-time AAO-HNS Distinguished Service Award Recipient

A special congratulations goes to **Richard M. Rosenfeld, MD, MPH, MBA,** for being the only five-time recipient of the AAO-HNS Distinguished Service Award (DSA) in Academy history.

Richard M. Rosenfeld, MD, MPH, MBA

Dr. Rosenfeld received his fifth DSA at the AAO-HNSF 2019 Annual Meeting & OTO Experience in New Orleans, LA. To achieve this, he earned a total of 250 lifetime honor points, making him the only Academy member in history who has reached this level of accomplishment.

The DSA represents an individual's service and volunteerism to the Academy, offering personal reward as well as benefit to the AAO-HNS/F and the specialty as a whole. "My engagement with AAO-HNS over nearly 30 years has been incredibly rewarding, both in terms of making a difference in the specialty and in my own personal and professional growth," said Dr. Rosenfeld.

Honor Awards and Distinguished Service Awards are part of the Academy's system for recognizing meritorious service. The DSA is a recognition of volunteer service beyond the level of an Honor Award. Members who attain 50 honor points receive the Distinguished Service Award. There is no limit on the number of Distinguished Service Awards a member may receive.

To learn more about Honor and Distinguished Service Awards, go to **https://www.entnet.org/content/honor-and-distinguished-service-awards.**

Five DSAs
Richard M. Rosenfeld, MD, MPH, MBA

Four DSAs
Mark K. Wax, MD

Three DSAs
Andrew Blitzer, MD, DDS
Karen H. Calhoun, MD
Sujana S. Chandrasekhar, MD
B. Tucker Woodson, MD

New Opportunity: Earn ABOHNS Continuing Certification credit with accredited CME

Brian Nussenbaum, MD, MHCM, Executive Director of the American Board of Otolaryngology—Head and Neck Surgery

Jeffrey P. Simons, MD, Coordinator for Education, American Academy of Otolaryngology–Head and Neck Surgery Foundation

Graham McMahon, MD, MMSc, President and CEO, Accreditation Council for Continuing Medical Education

The Accreditation Council for Continuing Medical Education (ACCME®) and the American Board of Otolaryngology – Head and Neck Surgery (ABOHNS) have collaborated to expand opportunities for ABOHNS Board-Certified Physicians to receive Continuing Certification (formerly known as Maintenance of Certification or MOC) credit for the high-quality accredited continuing medical education (CME) activities you are already participating in—including many of the activities offered by the American Academy of Otolaryngology–Head and Neck Surgery Foundation (AAO-HNSF).

Our goal is to increase the number and diversity of practice-relevant accredited CME activities that include a self-assessment component to meet the requirements for ABOHNS Continuing Certification and to reduce burdens—so that you can focus on education and learning, not on paperwork. Diplomates of the ABOHNS are required to complete one self-assessment activity each year. This can be accomplished with successful participation in CertLink or through completion of one of the CME activities also accredited for Continuing Certification credit through this collaboration between the ACCME and the ABOHNS. This improves alignment of learning activities that diplomates are already doing with Continuing Certification requirements.

CME + Continuing Certification: A simpler, unified process

Accredited CME activities are identified with the ABOHNS Continuing Certification Recognition Statement. You can search in CME Finder (http://www.cmefinder.org/), the ACCME's online search tool, for CME activities that count for ABOHNS Continuing Certification. The AAO-HNSF currently has more than 50 activities available, with the number continuing to increase.

Accredited CME providers will need to ask for your ABOHNS diplomate ID and date of birth (month and day only) to report this credit. You may also need to click a button or otherwise agree to have your participation information sent to ACCME. Your CME provider will transmit your participation information to the ACCME, and it then will be made available to ABOHNS; you do not need to report the participation to ABOHNS.

AAO-HNSF Opportunities for Continuing Certification

The AAO-HNSF has registered many of their activities for ABOHNS Lifelong Learning in CME Finder. Academy members can also access these courses through AcademyU.org Member+, an affordable subscription model of 200 CME courses for the price of one.

The AAO-HNSF 2019 Annual Meeting & OTO Experience held in New Orleans, LA, also provided full conference attendees the opportunity to earn up to 29 CME/MOC credits. As a bonus, 27 Annual Meeting Webcasts are available for enduring CME/MOC credit by completing the online course, posttest, and evaluation. All of these courses can be found at AcademyU.org.

Working Together

The ACCME, ABOHNS, and AAO-HNSF share a commitment to promoting safe, high-quality patient care and to supporting physicians' lifelong participation in meaningful and practice-relevant learning activities that can be integrated into the physician's normal workflow. By working together, ABOHNS, ACCME, the AAO-HNSF, other accredited CME providers, and ABOHNS Board-Certified Physicians can leverage the power of education to drive quality in our medical profession and improve care for the patients we all serve.

The collaboration with ABOHNS continues the ACCME's commitment to supporting the goals of continuing certification and to easing burdens on physicians by enabling them to meet multiple professional requirements by participating in accredited CME. The ACCME has also developed collaborations with these American Board of Medical Specialties member boards: the American Board of Anesthesiology, the American Board of Internal Medicine, the American Board of Ophthalmology, the American Board of Pathology, and the American Board of Pediatrics.

We welcome your feedback and questions. Please contact us at info@accme.org.

Look for the ABOHNS Continuing Certification Recognition Statement

The ABOHNS Continuing Certification Recognition Statement will be included in accredited CME activities that count for ABOHNS Continuing Certification credit:

"Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn their required annual part II self-assessment credit in the American Board of Otolaryngology – Head and Neck Surgery's Continuing Certification program (formerly known as MOC). It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of recognizing participation." ■

DUPIXENT®
(dupilumab) Injection 300mg

THE ONLY BIOLOGIC APPROVED IN CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS

INDICATION

DUPIXENT is indicated as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

DUPIXENT is **the first and only dual inhibitor of IL-4 and IL-13 signaling approved in CRSwNP**[1]

IMPORTANT SAFETY INFORMATION

CONTRAINDICATION: DUPIXENT is contraindicated in patients with known hypersensitivity to dupilumab or any of its excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity: Hypersensitivity reactions, including generalized urticaria, rash, erythema nodosum, anaphylaxis and serum sickness or serum sickness-like reactions, were reported in <1% of subjects who received DUPIXENT in clinical trials. If a clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue DUPIXENT.

Conjunctivitis and Keratitis: Conjunctivitis occurred more frequently in subjects with chronic rhinosinusitis with nasal polyposis who received DUPIXENT. There were no cases of keratitis reported in the CRSwNP development program. Advise patients to report new onset or worsening eye symptoms to their healthcare provider.

Eosinophilic Conditions: Patients being treated for asthma may present with serious systemic eosinophilia sometimes presenting with clinical features of eosinophilic pneumonia or vasculitis consistent with eosinophilic granulomatosis with polyangiitis (EGPA), conditions which are often treated with systemic corticosteroid therapy. These events may be associated with the reduction of oral corticosteroid therapy. Physicians should be alert to vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients with eosinophilia. Cases of eosinophilic pneumonia were reported in adult patients who participated in the asthma development program and cases of vasculitis consistent with EGPA have been reported with DUPIXENT in adult patients who participated in the asthma development program as well as in adult patients with co-morbid asthma in the CRSwNP development program. A causal association between DUPIXENT and these conditions has not been established.

Please see additional Important Safety Information throughout and brief summary of full Prescribing Information on the following pages.

DUPIXENT TRIALS ENROLLED A TOTAL POPULATION OF 724 PATIENTS WITH UNCONTROLLED CRSwNP DESPITE PRIOR SURGERY OR SCS USE[1,2]

	TRIAL 1 (N=276) 24 WEEKS	TRIAL 2 (N=448) 52 WEEKS
Randomized	**DUPIXENT + INCS** 300 mg Q2W for 24 weeks (n=143) Placebo + INCS for 24 weeks (n=133)	**DUPIXENT + INCS** 300 mg Q2W for 52 weeks (n=150)[a] **DUPIXENT + INCS** 300 mg Q2W for 24 weeks, followed by Q4W[b] through Week 52 (n=145)[a] Placebo + INCS for 52 weeks (n=153)
Study population	Adults (≥18 years) on background intranasal corticosteroids[c] with CRSwNP despite prior sino-nasal surgery or prior treatment with, or who were ineligible to receive or were intolerant to, systemic corticosteroids in the past 2 years Patients with chronic rhinosinusitis without nasal polyposis were not included in these trials Rescue with systemic corticosteroids or surgery was allowed at investigators' discretion The total population of patients in Trials 1 and 2 was unrestricted by minimum baseline blood eosinophil count	
Coprimary endpoints	Change from baseline at Week 24 in: • Nasal congestion/obstruction score averaged over 28 days (NC) • Bilateral endoscopic nasal polyp score (NPS)	
Key secondary endpoints	Change from baseline at Week 24 in: • Daily loss of smell score • LMK-CT score • SNOT-22 score	Change from baseline at Weeks 24 and 52 in: • NC score (at Week 52) • NPS (at Week 52) • Daily loss of smell score • LMK-CT score • SNOT-22 score
Prespecified pooled analysis	Change from baseline at Week 52 in proportion of patients requiring SCS or sino-nasal surgery	

[a] In Trial 2, data from baseline to Week 24 are pooled from DUPIXENT Q2W treatment arms (n=295).

[b] **The recommended dose of DUPIXENT for adult patients with CRSwNP is 300 mg given subcutaneously every other week.**

[c] All patients in the placebo and DUPIXENT arms were on a background therapy of intranasal corticosteroids (INCS), mometasone furoate nasal spray.

Patient demographics

TRIAL 1: 24 WEEKS (N=276)–Mean age: 50 years; male: 57%; mean CRSwNP duration: 11 years; patients with ≥1 prior surgery: 72%; patients with SCS use in previous 2 years: 65%; mean bilateral endoscopic NPS,[d] range 0-8: 5.8; mean nasal congestion (NC) score,[d] range 0-3: 2.4; mean LMK sinus CT total score,[d] range 0-24: 19; mean loss of smell score[d] (AM), range 0-3: 2.7; mean SNOT-22 total score,[d] range 0-110: 49.4; mean blood eosinophil count: 440 cells/µL; mean total IgE: 212 IU/mL; atopic medical history, overall: 75%; asthma: 58%; NSAID-ERD: 30%.

TRIAL 2: 52 WEEKS (N=448)–Mean age: 52 years; male: 62%; mean CRSwNP duration: 11 years; patients with ≥1 prior surgery: 58%; patients with SCS use in previous 2 years: 80%; mean bilateral endoscopic NPS,[d] range 0-8: 6.1; mean nasal congestion (NC) score,[d] range 0-3: 2.4; mean LMK sinus CT total score,[d] range 0-24: 18; mean loss of smell score[d] (AM), range 0-3: 2.8; mean SNOT-22 total score,[d] range 0-110: 51.9; mean blood eosinophil count: 430 cells/µL; mean total IgE: 240 IU/mL; atopic medical history, overall: 82%; asthma: 60%; NSAID-ERD: 27%.

In Trials 1 and 2, all subjects had evidence of sinus opacification on the Lund-Mackay (LMK) sinus CT scan, and 73% to 90% of subjects had opacification of all sinuses. Prior surgery patients had a mean number of 2.0 prior surgeries, and SCS use patients had 1.6 SCS courses in the previous 2 years.

~79% of patients enrolled in both trials had atopic diseases

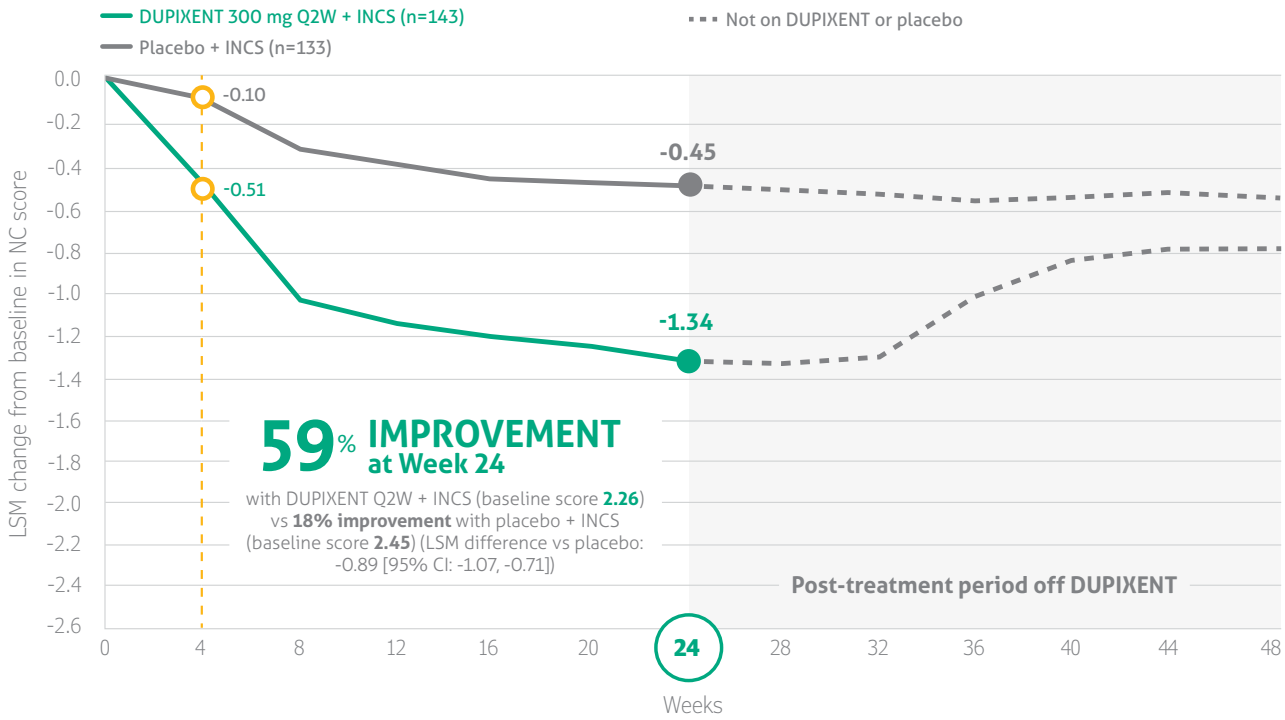
[d] Higher scores indicate greater disease severity.

AM, morning; LMK-CT, Lund-Mackay computed tomography; NSAID-ERD, nonsteroidal anti-inflammatory drug-exacerbated respiratory disease; Q2W, once every 2 weeks; Q4W, once every 4 weeks; SCS, systemic corticosteroid; SNOT-22, 22-Item Sino-Nasal Outcome Test.

DUPIXENT RAPIDLY IMPROVED NASAL CONGESTION AND OBSTRUCTION AS EARLY AS WEEK 4 AND AT WEEK 24

Significantly improved NC score and NPS vs placebo at Week 24 (primary endpoints)[1-3]

Change in NC score through Week 48 in Trial 1



NC score improved as early as Week 4 in Trial 1 (LSM difference vs placebo: -0.41 [95% CI: -0.52, -0.30])[1]

NPS at Week 24 (Trial 1: coprimary endpoint)[1]

- **34% IMPROVEMENT** with DUPIXENT Q2W + INCS (n=143) (**-1.89** from a baseline score of **5.64**) vs **3% worsening** with placebo + INCS (n=133) (**0.17** from a baseline score of **5.86**) (LSM difference: -2.06 [95% CI: -2.43, -1.69])

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

Reduction of Corticosteroid Dosage: Do not discontinue systemic, topical, or inhaled corticosteroids abruptly upon initiation with DUPIXENT. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

NC score (range 0 to 3): reduced score indicates improvement; NPS (range 0 to 8): reduced score indicates improvement.

LSM, least squares mean.

DUPIXENT RAPIDLY IMPROVED NASAL CONGESTION AND OBSTRUCTION AS EARLY AS WEEK 4, AT WEEK 24, AND SUSTAINED THROUGH 52 WEEKS

Significantly improved NC score and NPS vs placebo at Weeks 24 (primary endpoints) and 52 (secondary endpoints) in Trial 2[1-3]

At Week 24

51% **IMPROVEMENT IN NC SCORE**

with DUPIXENT Q2W + INCS (n=295, pooled DUPIXENT arms) (**-1.25** from a baseline score of **2.46**) vs **16% improvement** with placebo + INCS (n=153) (**-0.38** from a baseline score of **2.38**) (LSM difference: -0.87 [95% CI: -1.03, -0.71])

At Week 52

54% **IMPROVEMENT IN NC SCORE**

with DUPIXENT Q2W + INCS (n=150) (**-1.35** from a baseline score of **2.48**) vs **16% improvement** with placebo + INCS (n=153) (**-0.37** from a baseline score of **2.38**) (LSM difference: -0.98 [95% CI: -1.17, -0.79])

NC score improved as early as Week 4 in Trial 2

-0.52 with DUPIXENT Q2W + INCS (n=295, pooled DUPIXENT arms) vs **-0.16** with placebo + INCS (n=153) (LSM difference: -0.37 [95% CI: -0.46, -0.27])[1,2]

NPS at Week 24 (Trial 2: coprimary endpoint)[1]

- **28% IMPROVEMENT** with DUPIXENT Q2W + INCS (n=295, pooled DUPIXENT arms) (**-1.71** from a baseline score of **6.18**) vs **2% worsening** with placebo + INCS (n=153) (**0.10** from a baseline score of **5.96**) (LSM difference: -1.80 [95% CI: -2.10, -1.51])

NPS at Week 52 (Trial 2: secondary endpoint)[1-3]

- **37% IMPROVEMENT** with DUPIXENT Q2W + INCS (n=150) (**-2.24** from a baseline score of **6.07**) vs **3% worsening** with placebo + INCS (n=153) (**0.15** from a baseline score of **5.96**) (LSM difference: -2.40 [95% CI: -2.77, -2.02])

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

Patients with Co-Morbid Asthma: Advise patients with co-morbid asthma not to adjust or stop their asthma treatments without consultation with their physician.

Parasitic (Helminth) Infections: It is unknown if DUPIXENT will influence the immune response against helminth infections. Treat patients with pre-existing helminth infections before initiating therapy with DUPIXENT. If patients become infected while receiving treatment with DUPIXENT and do not respond to anti-helminth treatment, discontinue treatment with DUPIXENT until the infection resolves.

Please see additional Important Safety Information throughout and brief summary of full Prescribing Information on the following pages.

DUPIXENT REDUCED SCS USE AND NEED FOR SINO-NASAL SURGERY

Significantly reduced SCS use or the need for sino-nasal surgery vs placebo over 52 weeks in a pooled analysis of Trials 1 and 2 (HR: 0.24 [95% CI: 0.17, 0.35])[1]

DUPIXENT 300 mg Q2W + INCS (Day 0: n=438; Week 24: n=376; Week 52: n=100);
vs placebo + INCS (Day 0: n=286; Week 24: n=187; Week 52: n=61)

74% REDUCTION IN THE PROPORTION OF PATIENTS WHO REQUIRED SCS USE AT WEEK 52[a]

(HR: 0.26 [95% CI: 0.18, 0.38])

75% REDUCTION in SCS courses per year (RR: 0.25 [95% CI: 0.17, 0.37])[a]

83% REDUCTION IN THE PROPORTION OF PATIENTS WHO REQUIRED SINO-NASAL SURGERY AT WEEK 52[a]

(HR: 0.17 [95% CI: 0.07, 0.46])

[a] Individually, SCS reduction and need for sino-nasal surgery were not multiplicity adjusted endpoints.

HR, hazard ratio; RR, risk ratio.

Safety Data

The safety profile of DUPIXENT Q2W through Week 52 was generally consistent with the safety profile observed at Week 24.

In the safety pool, the proportion of subjects who discontinued treatment due to adverse events was 5% in the placebo group and 2% in the DUPIXENT Q2W group.

In subjects with CRSwNP, the frequency of conjunctivitis was 2% in the DUPIXENT group compared with 1% in the placebo group in the 24-week safety pool; these subjects recovered. There were no cases of keratitis reported in the CRSwNP development program.

In Trial 2 (52 weeks), the frequency of conjunctivitis was 3% in the DUPIXENT group compared with 1% in the placebo group; all of these subjects recovered.

IMPORTANT SAFETY INFORMATION

ADVERSE REACTIONS: The most common adverse reactions (incidence ≥1%) in patients with CRSwNP are injection site reactions, eosinophilia, insomnia, toothache, gastritis, arthralgia, and conjunctivitis.

DRUG INTERACTIONS: Avoid use of live vaccines in patients treated with DUPIXENT.

DUPIXENT® (dupilumab) Injection 300mg

Visit **DupixentHCP.com/CRSwNP**

DUPIXENT RAPIDLY IMPROVED DAILY LOSS OF SMELL SCORE AS EARLY AS WEEK 4, SUSTAINED THROUGH 52 WEEKS

Significantly improved daily loss of smell score vs placebo at Weeks 24 and 52 (secondary endpoints)[1-3]

46% IMPROVEMENT AT WEEK 52 IN TRIAL 2

with DUPIXENT Q2W + INCS (n=150) (**-1.29** from a baseline score of **2.81**) vs **7% improvement** with placebo + INCS (n=153) (**-0.19** from a baseline score of **2.72**) (LSM difference: -1.10 [95% CI: -1.31, -0.89])[1-3]

Daily loss of smell score improved as early as Week 4 in Trial 2

- **-0.38** with DUPIXENT Q2W + INCS (n=295, pooled DUPIXENT arms) vs **-0.07** with placebo + INCS (n=153) (LSM difference vs placebo: -0.31 [95% CI: -0.41, -0.22])[3]

Daily loss of smell score at Week 24 (Trial 2: secondary endpoint)[1,3]

- **44% IMPROVEMENT** with DUPIXENT Q2W + INCS (n=295, pooled DUPIXENT arms) (**-1.21** from a baseline score of **2.77**) vs **8% improvement** with placebo + INCS (n=153) (**-0.23** from a baseline score of **2.72**) (LSM difference: -0.98 [95% CI: -1.15, -0.81])

Daily loss of smell score at Week 24 (Trial 1: secondary endpoint)[1,3]

- **52% IMPROVEMENT** with DUPIXENT Q2W + INCS (n=143) (**-1.41** from a baseline score of **2.70**) vs **11% improvement** with placebo + INCS (n=133) (**-0.29** from a baseline score of **2.73**) (LSM difference: -1.12 [95% CI: -1.31, -0.93])

IMPORTANT SAFETY INFORMATION

USE IN SPECIFIC POPULATIONS

- **Pregnancy:** Available data from case reports and case series with DUPIXENT use in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage or adverse maternal or fetal outcomes. Human IgG antibodies are known to cross the placental barrier; therefore, DUPIXENT may be transmitted from the mother to the developing fetus.
- **Lactation:** There are no data on the presence of DUPIXENT in human milk, the effects on the breastfed infant, or the effects on milk production. Maternal IgG is known to be present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for DUPIXENT and any potential adverse effects on the breastfed child from DUPIXENT or from the underlying maternal condition.

Daily loss of smell score (range 0 to 3): reduced score indicates improvement.

References: 1. DUPIXENT Prescribing Information. **2.** Data on file, Sanofi US. 2019. **3.** Data on file, Sanofi US. CSR SAR231893/REGN668, 2018.

DUPIXENT® (dupilumab) Injection 300mg

Please see brief summary of full Prescribing Information on the following pages.

SANOFI GENZYME

REGENERON

DUP.19.08.0248

DUPIXENT® (dupilumab) injection, for subcutaneous use **Rx only**

Brief Summary of Prescribing Information

1 INDICATIONS AND USAGE

1.3 Chronic Rhinosinusitis with Nasal Polyposis

DUPIXENT is indicated as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

4 CONTRAINDICATIONS

DUPIXENT is contraindicated in patients who have known hypersensitivity to dupilumab or any of its excipients *[see Warnings and Precautions (5.1)]*.

5 WARNINGS AND PRECAUTIONS

5.1 Hypersensitivity

Hypersensitivity reactions, including generalized urticaria, rash, erythema nodosum and serum sickness or serum sickness-like reactions, were reported in less than 1% of subjects who received DUPIXENT in clinical trials. If a clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue DUPIXENT *[see Adverse Reactions (6.1, 6.2)]*.

5.2 Conjunctivitis and Keratitis

In subjects with CRSwNP, the frequency of conjunctivitis was 2% in the DUPIXENT group compared to 1% in the placebo group in the 24-week safety pool; these subjects recovered. There were no cases of keratitis reported in the CRSwNP development program *[see Adverse Reactions (6.1)]*.

Advise patients to report new onset or worsening eye symptoms to their healthcare provider.

5.3 Eosinophilic Conditions

Patients being treated for asthma may present with serious systemic eosinophilia sometimes presenting with clinical features of eosinophilic pneumonia or vasculitis consistent with eosinophilic granulomatosis with polyangiitis, conditions which are often treated with systemic corticosteroid therapy. These events may be associated with the reduction of oral corticosteroid therapy. Physicians should be alert to vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients with eosinophilia. Cases of eosinophilic pneumonia were reported in adult patients who participated in the asthma development program and cases of vasculitis consistent with eosinophilic granulomatosis with polyangiitis have been reported with DUPIXENT in adult patients who participated in the asthma development program as well as in adult patients with co-morbid asthma in the CRSwNP development program. A causal association between DUPIXENT and these conditions has not been established.

5.5 Reduction of Corticosteroid Dosage

Do not discontinue systemic, topical, or inhaled corticosteroids abruptly upon initiation of therapy with DUPIXENT. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

5.6 Patients with Comorbid Asthma

Advise patients with CRSwNP who have co-morbid asthma not to adjust or stop their asthma treatments without consultation with their physicians.

5.7 Parasitic (Helminth) Infections

Patients with known helminth infections were excluded from participation in clinical studies. It is unknown if DUPIXENT will influence the immune response against helminth infections.

Treat patients with pre-existing helminth infections before initiating therapy with DUPIXENT. If patients become infected while receiving treatment with DUPIXENT and do not respond to antihelminth treatment, discontinue treatment with DUPIXENT until the infection resolves.

6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail elsewhere in the labeling:

- Hypersensitivity *[see Warnings and Precautions (5.1)]*
- Conjunctivitis and Keratitis *[see Warnings and Precautions (5.2)]*

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.

Chronic Rhinosinusitis with Nasal Polyposis

A total of 722 adult subjects with chronic rhinosinusitis with nasal polyposis (CRSwNP) were evaluated in 2 randomized, placebo-controlled, multicenter trials of 24 to 52 weeks duration (CSNP Trials 1 and 2). The safety pool consisted of data from the first 24 weeks of treatment from both studies.

In the safety pool, the proportion of subjects who discontinued treatment due to adverse events was 5% of the placebo group and 2% of the DUPIXENT 300 mg Q2W group.

Table 4 summarizes the adverse reactions that occurred at a rate of at least 1% in subjects treated with DUPIXENT and at a higher rate than in their respective comparator group in CSNP Trials 1 and 2.

Table 4: Adverse Reactions Occurring in ≥1% of the DUPIXENT Group in CRSwNP Trials 1 and 2 and Greater than Placebo (24 Week Safety Pool)

Adverse Reaction	CSNP Trial 1 and Trial 2	
	DUPIXENT 300 mg Q2W N=440 n (%)	Placebo N=282 n (%)
Injection site reactions[a]	28 (6%)	12 (4%)
Conjunctivitis[b]	7 (2%)	2 (1%)
Arthralgia	14 (3%)	5 (2%)
Gastritis	7 (2%)	2 (1%)
Insomnia	6 (1%)	0 (<1%)
Eosinophilia	5 (1%)	1 (<1%)
Toothache	5 (1%)	1 (<1%)

[a] Injection site reactions cluster includes injection site reaction, pain, bruising and swelling.

[b] Conjunctivitis cluster includes conjunctivitis, allergic conjunctivitis, bacterial conjunctivitis, viral conjunctivitis, giant papillary conjunctivitis, eye irritation, and eye inflammation.

The safety profile of DUPIXENT through Week 52 was generally consistent with the safety profile observed at Week 24.

Specific Adverse Reactions

Conjunctivitis

In the 52-week CRSwNP study (CSNP Trial 2), the frequency of conjunctivitis was 3% in the DUPIXENT subjects and 1% in the placebo subjects; all of these subjects recovered *[see Warnings and Precautions (5.2)]*.

Eczema Herpeticum and Herpes Zoster

Among CRSwNP subjects there were no reported cases of herpes zoster or eczema herpeticum.

Hypersensitivity Reactions

Hypersensitivity reactions were reported in <1% of DUPIXENT-treated subjects. These included serum sickness reaction, serum sickness-like reaction, generalized urticaria, rash, erythema nodosum, and anaphylaxis *[see Contraindications (4), Warnings and Precautions (5.1), and Adverse Reactions (6.2)]*.

Eosinophils

DUPIXENT-treated subjects had a greater initial increase from baseline in blood eosinophil count compared to subjects treated with placebo. In subjects with CRSwNP, the mean and median increases in blood eosinophils from baseline to Week 16 were 150 and 50 cells/mcL, respectively.

Across all indications, the incidence of treatment-emergent eosinophilia (≥500 cells/mcL) was similar in DUPIXENT and placebo groups. Treatment-emergent eosinophilia (≥5,000 cells/mcL) was reported in <2% of DUPIXENT-treated patients and <0.5% in placebo-treated patients. Blood eosinophil counts declined to near baseline levels during study treatment *[see Warnings and Precautions (5.3)]*.

Cardiovascular (CV)

In the 24-week placebo controlled trial in subjects with CRSwNP (CSNP Trial 1), CV thromboembolic events (CV deaths, non-fatal myocardial infarctions, and non-fatal strokes) were reported in 1 (0.7%) of the DUPIXENT group and 0 (0.0%) of the placebo group. In the 1-year placebo controlled trial in subjects with CRSwNP (CSNP Trial 2), there were no cases of CV thromboembolic events (CV deaths, non-fatal myocardial infarctions, and non-fatal strokes) reported in any treatment arm.

6.2 Immunogenicity

As with all therapeutic proteins, there is a potential for immunogenicity. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors, including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to dupilumab in the studies described below with the incidence of antibodies in other studies or to other products may be misleading.

Approximately 5% of subjects with atopic dermatitis, asthma, or CRSwNP who received DUPIXENT 300 mg Q2W for 52 weeks developed antibodies to dupilumab; ~2% exhibited persistent ADA responses, and ~2% had neutralizing antibodies.

Approximately 4% of subjects in the placebo groups in the 52-week studies were positive for antibodies to DUPIXENT; approximately 2% exhibited persistent ADA responses, and approximately 1% had neutralizing antibodies.

The antibody titers detected in both DUPIXENT and placebo subjects were mostly low. In subjects who received DUPIXENT, development of high titer antibodies to dupilumab was associated with lower serum dupilumab concentrations *[see Clinical Pharmacology (12.3) in the full Prescribing Information]*.

Two subjects who experienced high titer antibody responses developed serum sickness or serum sickness-like reactions during DUPIXENT therapy *[see Warnings and Precautions (5.1)]*.

7 DRUG INTERACTIONS

7.1 Live Vaccines

Avoid use of live vaccines in patients treated with DUPIXENT.

7.2 Non-Live Vaccines

Immune responses to vaccination were assessed in a study in which subjects with atopic dermatitis were treated once weekly for 16 weeks with 300 mg of dupilumab (twice the recommended dosing frequency). After 12 weeks of DUPIXENT administration, subjects were vaccinated with a Tdap vaccine (Adacel®) and a meningococcal polysaccharide vaccine (Menomune®). Antibody responses to tetanus toxoid and serogroup C meningococcal polysaccharide were assessed 4 weeks later. Antibody responses to both tetanus vaccine and meningococcal polysaccharide vaccine were similar in dupilumab-treated and placebo-treated subjects. Immune responses to the other active components of the Adacel and Menomune vaccines were not assessed.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to DUPIXENT during pregnancy.

Please contact 1-877-311-8972 or go to https://mothertobaby.org/ongoing-study/dupixent/ to enroll in or to obtain information about the registry.

Risk Summary

Available data from case reports and case series with DUPIXENT use in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Human IgG antibodies are known to cross the placental barrier; therefore, DUPIXENT may be transmitted from the mother to the developing fetus. In an enhanced pre- and post-natal developmental study, no adverse developmental effects were observed in offspring born to pregnant monkeys after subcutaneous administration of a homologous antibody against interleukin-4-receptor alpha (IL-4Rα) during organogenesis through parturition at doses up to 10-times the maximum recommended human dose (MRHD) *(see Data)*. The estimated background risk of major birth defects and miscarriage for the indicated populations are unknown. All pregnancies have a background risk of birth defect, loss or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Data

Animal Data

In an enhanced pre- and post-natal development toxicity study, pregnant cynomolgus monkeys were administered weekly subcutaneous doses of homologous antibody against IL-4Rα up to 10-times the MRHD (on a mg/kg basis of 100 mg/kg/week) from the beginning of organogenesis to parturition. No treatment-related adverse effects on embryofetal toxicity or malformations, or on morphological, functional, or immunological development were observed in the infants from birth through 6 months of age.

8.2 Lactation

Risk Summary

There are no data on the presence of dupilumab in human milk, the effects on the breastfed infant, or the effects on milk production. Maternal IgG is known to be present in human milk. The effects of local gastrointestinal and limited systemic exposure to dupilumab on the breastfed infant are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for DUPIXENT and any potential adverse effects on the breastfed child from DUPIXENT or from the underlying maternal condition.

8.4 Pediatric Use

CRSwNP

CRSwNP does not normally occur in children. Safety and efficacy in pediatric patients (<18 years of age) with CRSwNP have not been established.

8.5 Geriatric Use

Of the 440 subjects with CRSwNP exposed to DUPIXENT, a total of 79 subjects were 65 years or older. Efficacy and safety in this age group were similar to the overall study population.

10 OVERDOSE

There is no specific treatment for DUPIXENT overdose. In the event of overdosage, monitor the patient for any signs or symptoms of adverse reactions and institute appropriate symptomatic treatment immediately.

17 PATIENT COUNSELING INFORMATION

Advise the patients and/or caregivers to read the FDA-approved patient labeling (Patient Information and Instructions for Use).

Pregnancy Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to DUPIXENT during pregnancy. Encourage participation in the registry *[see Use in Specific Populations (8.1)]*.

Administration Instructions

Provide proper training to patients and/or caregivers on proper subcutaneous injection technique, including aseptic technique, and the preparation and administration of DUPIXENT prior to use. Advise patients to follow sharps disposal recommendations *[see Instructions for Use]*.

Hypersensitivity

Advise patients to discontinue DUPIXENT and to seek immediate medical attention if they experience any symptoms of systemic hypersensitivity reactions *[see Warnings and Precautions (5.1)]*.

Conjunctivitis and Keratitis

Advise patients to consult their healthcare provider if new onset or worsening eye symptoms develop *[see Warnings and Precautions (5.2)]*.

Eosinophilic Conditions

Advise patients to notify their healthcare provider if they present with clinical features of eosinophilic pneumonia or vasculitis consistent with eosinophilic granulomatosis with polyangiitis *[see Warnings and Precautions (5.3)]*.

Reduction in Corticosteroid Dosage

Inform patients to not discontinue systemic or inhaled corticosteroids except under the direct supervision of a physician. Inform patients that reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy *[see Warnings and Precautions (5.5)]*.

Patients with Comorbid Asthma

Advise patients with atopic dermatitis or CRSwNP who have comorbid asthma not to adjust or stop their asthma treatment without talking to their physicians *[see Warnings and Precautions (5.6)]*.

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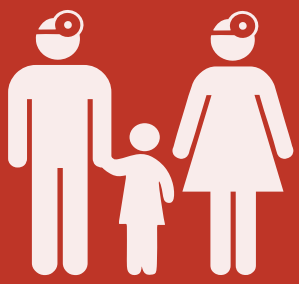

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FOR MORE INFORMATION, PLEASE CONTACT:
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anippert@pennstatehealth.psu.edu.

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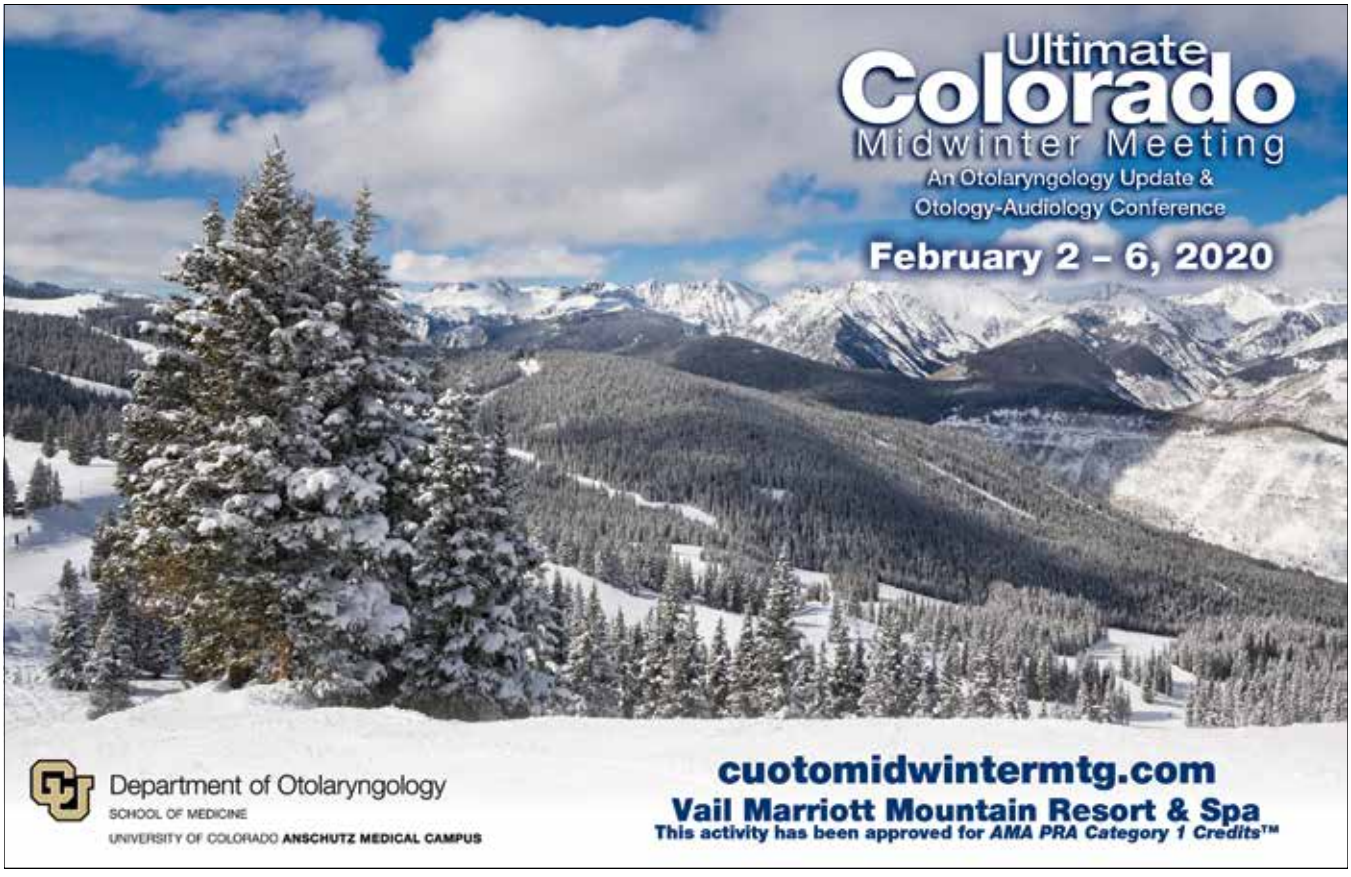

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Interested candidates should submit a letter of intent, curriculum vitae and three letters of recommendation to:

Michael Cunningham, MD
Otolaryngologist-in-Chief, Boston Children's Hospital
Professor of Otolaryngology, Harvard Medical School
300 Longwood Ave., BCH3129
Boston, MA 02115
Email: michael.cunningham@childrens.harvard.edu

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Professor and Chairman
Department of Otolaryngology-Head & Neck Surgery
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Or email skountakis@augusta.edu

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Department of Otolaryngology-HNS
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Children's Hospital of the King's Daughters
601 Children's Lane, 2nd Floor, ENT suite
Norfolk, VA 23507
(757) 668-9853
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BC/BE General Otolaryngologist

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Send letter of interest and CV to:

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

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David W. Eisele, MD, FACS
Andelot Professor and Director
Department of Otolaryngology-Head and Neck Surgery
Johns Hopkins University School of Medicine
601 North Caroline St., Suite 6210
Baltimore, MD 21287

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Required Qualifications: MD/DO Degree. Board Certified or Board Eligible and Fellowship trained in Otolaryngology and eligible for, or have a license to practice medicine in New York State. The candidate will have demonstrated clinical and research capabilities, interest and experience in teaching and supervision of undergraduate, medical students and residents.

Preferred Qualifications: Experience in an academic medical facility with an active clinical practice. Demonstrated experience in research and the mentoring of residents and medical students. Publications and clinical experience in Otolaryngology/Laryngology.

Application Procedure:

1. Complete the online Applicant Information Survey. Do not submit this survey to the department with your application. Any questions regarding the survey, please email **oide@stonybrook.edu**.
2. Submit a State Employment Application, cover letter and resume/CV to the departmental address or fax below.

David A. Schessel, MD, PhD
Chief and Associate Professor of Surgery, Otolaryngology, Head and Neck Surgery, Medical Director of Speech and Hearing
C/O Debbie Morganelli, Department of Surgery, Stony Brook Medicine
Health Science Center Level 19, room 068
Stony Brook, NY 11794-8191, Fax: (631) 444-8947

For a full position description or application procedures, visit:
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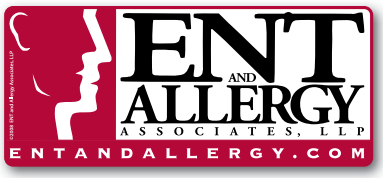

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Experience and/or a practice focus in comprehensive otolaryngology - head and neck surgery is preferred.

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Letters of inquiry and curriculum vitae should be sent to:

Maie A. St. John, M.D., Ph.D., FACS
Professor and Chair, Department of Head & Neck Surgery
Thomas C. Calcaterra Chair in Head and Neck Surgery
Co-Director, UCLA Head and Neck Cancer Program
Jonsson Comprehensive Cancer Center
David Geffen School of Medicine at UCLA
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To apply, please go to https://facultyjobs.hr.ufl.edu, search using "Otolaryngology, Gainesville". After applying, please send your CV and cover letter to:

Department of Otolaryngology
Attn: Neil Chheda, MD University of Florida
PO Box 100264
Gainesville, FL 32610-0264
Email: neil.chheda@ent.ufl.edu

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Academic Faculty Position, Pediatric Otolaryngology

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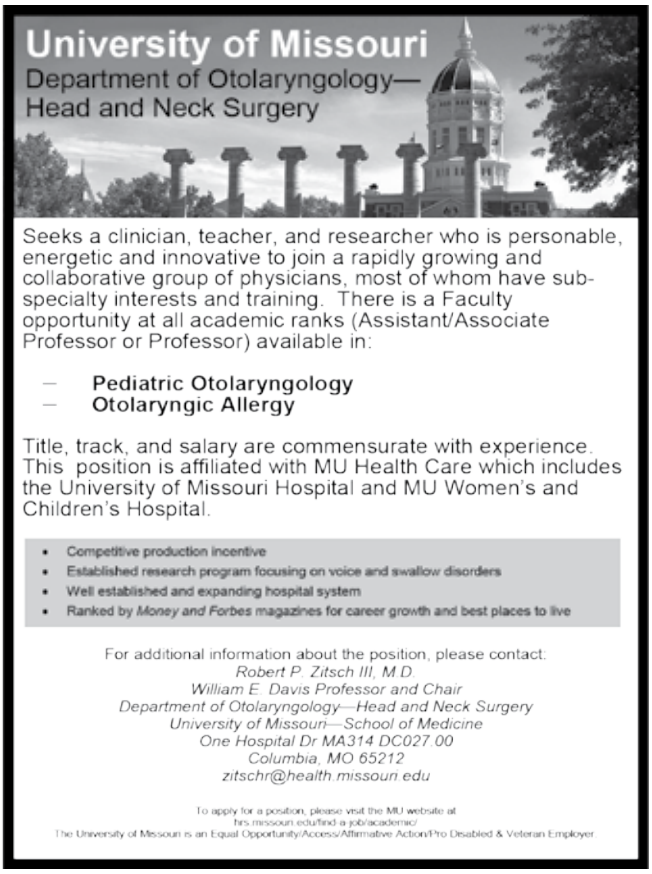
Keiko Hirose, MD
Division Chief, Pediatric Otolaryngology
Department of Otolaryngology-Head & Neck Surgery
Washington University School of Medicine

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

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



Seeks a clinician, teacher, and researcher who is personable, energetic and innovative to join a rapidly growing and collaborative group of physicians, most of whom have sub-specialty interests and training. There is a Faculty opportunity at all academic ranks (Assistant/Associate Professor or Professor) available in:

- Pediatric Otolaryngology
- Otolaryngic Allergy

Title, track, and salary are commensurate with experience. This position is affiliated with MU Health Care which includes the University of Missouri Hospital and MU Women's and Children's Hospital.

- Competitive production incentive
- Established research program focusing on voice and swallow disorders
- Well established and expanding hospital system
- Ranked by *Money and Forbes* magazines for career growth and best places to live

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

To apply for a position, please visit the MU website at
hrs.missouri.edu/find-a-job/academic/
The University of Missouri is an Equal Opportunity/Access/Affirmative Action/Pro Disabled & Veteran Employer

Head & Neck Oncologic Surgeon

The University of Utah Department of Surgery, Division of Otolaryngology – Head & Neck Surgery seeks a BC/BE faculty with an interest in oncologic surgery. This is a full-time clinical track position at the Assistant Professor level. Responsibilities will include teaching, research, and clinical care at the University of Utah Health as well as at the Huntsman Cancer Institute, which is an NCI-Designated Comprehensive Cancer Center. Position available July, 2020.

Applicants must apply at:
http://utah.peopleadmin.com/postings/96512
For additional information, contact:
Susan Harrison
801-585-3186
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.

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

General Otorhinolaryngology Faculty Positions

The Department of Otorhinolaryngology-Head & Neck Surgery is recruiting up to 3 general otorhinolaryngologists to join its expanding suburban practices. This is a unique opportunity to join a growing academic department in a large metro area. Interest in sleep and/or allergy is desirable, but not required. These positions also involve a 20% commitment to the Department's teaching sites. Academic appointment commensurate with experience.

Please submit your CV and application here: **www.ent4.me/recruit**

Interest and questions may be directed to:
Martin J. Citardi, MD
Professor & Chair
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

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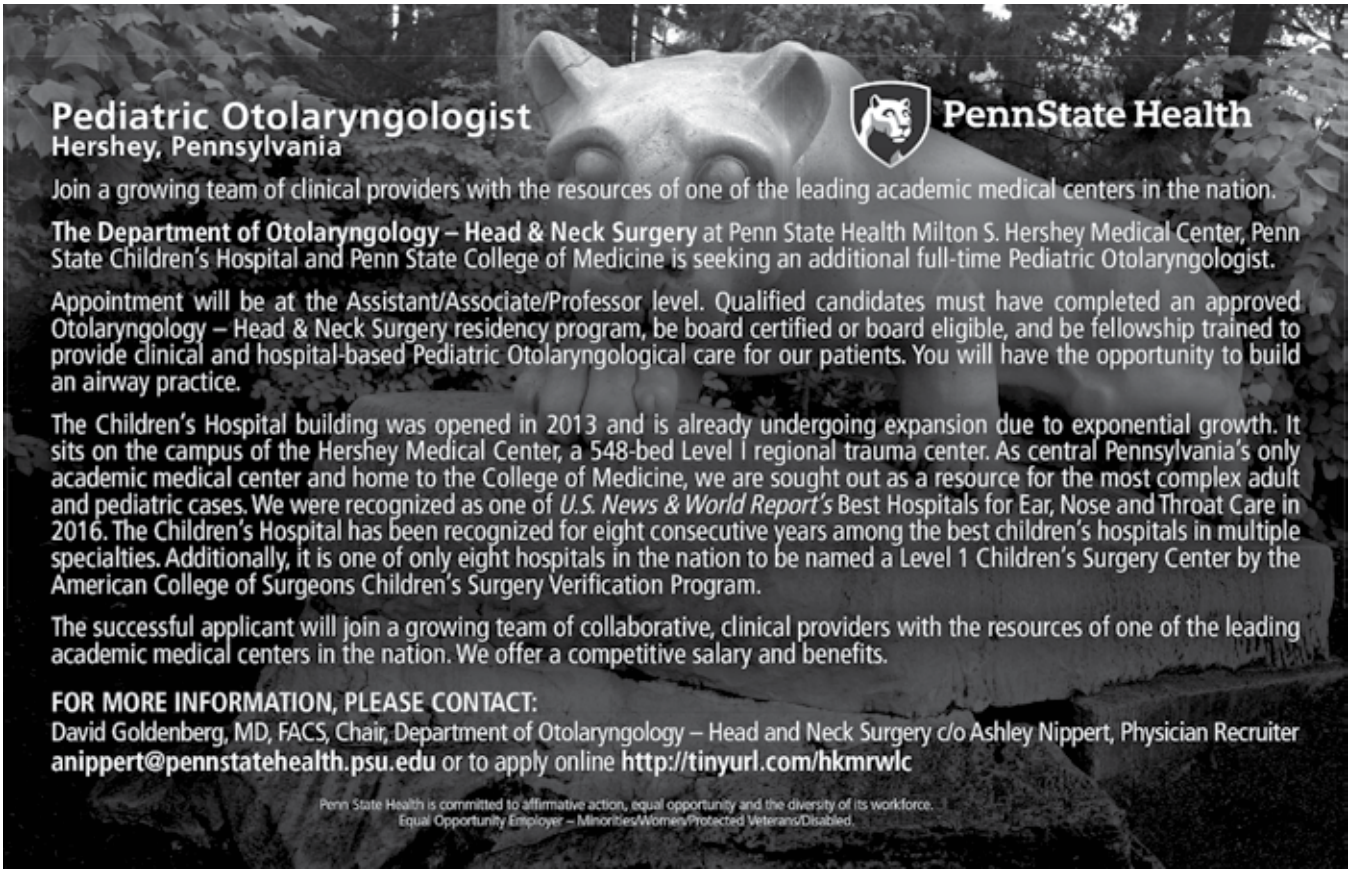

CLINICAL FELLOWSHIP IN LARYNGEAL SURGERY AND VOICE DISORDERS

Massachusetts General Hospital

The Division of Laryngeal Surgery is seeking applicants for clinical fellowship positions. The fellowship training covers all aspects of laryngeal surgery, voice disorders, and management of the professional voice. The curriculum will provide a wide range of experiences, including phonomicrosurgery (cold instruments and lasers), laryngeal framework surgery, novel operating-room and office-based laser (Pulsed-KTP, Thulium) treatment, complex laryngeal stenosis with aortic homograft transplantation, and the use of botulinum toxin injections for spasmodic dysphonia. The fellow will participate in the management of voice disorders and clinical research as a member of a multidisciplinary team (voice scientists and speech pathologists) that has access to state-of the-art voice clinic and surgical engineering laboratory facilities. The research fellowship provides numerous opportunities to focus on grant-funded (NIH and private foundations) clinical and basic science research projects in collaboration with interdisciplinary teams of scientists and clinicians at the Massachusetts Institute of Technology and the Wellman Laboratories of Photomedicine at the Massachusetts General Hospital. The option to collaborate with local music conservatories is also available. Qualified minority and female candidates are encouraged to apply. Send curriculum vitae and three letters of recommendation. The Massachusetts General Hospital is a teaching affiliate of Harvard Medical School.

Direct inquiries to:
Steven M. Zeitels, MD, FACS
Eugene B. Casey Professor of Laryngeal Surgery, Harvard Medical School
Director: Center for Laryngeal Surgery & Voice Rehabilitation
Massachusetts General Hospital
One Bowdoin Square, 11th Floor
Boston, MA 02114
Telephone: (617) 726-0210 Fax: (617) 726-0222
zeitels.steven@mgh.harvard.edu

UF UNIVERSITY of FLORIDA

The Department of Otolaryngology at the University of Florida is seeking applicants who wish to pursue an academic career in General Otolaryngology at the rank of Assistant, Associate, or Full Professor. Track and rank will be commensurate with experience. The department has 16 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 https://facultyjobs.hr.ufl.edu, search using "Otolaryngology, Gainesville". After applying, please send your CV and cover letter to:

Department of Otolaryngology
Attn: Brian Lobo, MD
University of Florida
PO Box 100264
Gainesville FL 32610-0264
Email:brian.lobo@ent.ufl.edu

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

Otorhinolaryngology: Established Hospital Employed Practice

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If you're interested in becoming part of our community, please contact:

Rebecca Banco, CMSR, DASPR, Physician Recruiter
802.747.3844 or **bbanco@rrmc.org**

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Otolaryngologist
Department of Otolaryngology- Head and Neck Surgery
Washington University School of Medicine

The Department of Otolaryngology-Head and Neck Surgery at Washington University School of Medicine in St. Louis, MO is seeking a Board certified or Board eligible physician(s) to provide patient care with a focus in comprehensive otolaryngology. Teaching of residents and medical students is expected. A variety of research opportunities are available. The clinical environment may include the main campus, as well as community locations in West, North and/or South St. Louis County. Applicants may apply for an assistant, associate or full professor appointment based on prior experience and training. The department has vast opportunity to provide cutting edge patient care in addition to basic, translational and clinical research experience. Collaboration with existing departmental clinical and basic investigators is encouraged. Salary is negotiable and commensurate with rank, training and experience.

Interested candidates should apply at https://facultyopportunities.wustl.edu.

Otolaryngologist

Expanding Practice in York, PA

A well established, busy five physician group in York, Pennsylvania is looking to add a sixth, full time Board Eligible/Board Certified Otolaryngologist. Our services include Audiology and Hearing Aid Sales. Our office has been running on an EMR system since 2006. On-Call rotation is 1:6. 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.

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

YORK ENT associates 50th ANNIVERSARY

Contact: Renee Gohn
Office: 717-843-9089 **Email: yorkent@comcast.net**

HOUSTON Methodist
LEADING MEDICINE

We are seeking candidates for the following positions:

Division Chief Head and Neck Surgery

BC/Fellowship Trained

Otolaryngology Hospitalist

BC/BE

Otolaryngology Sleep Surgeon

BC/BE

Otolaryngology Generalists (Community-based)

BC/BE

Houston Methodist is an equal opportunity, affirmative action institution which proudly values diversity and candidates of all backgrounds.

The Department of Otolaryngology – Head and Neck Surgery at Houston Methodist is actively recruiting a Division Chief of Head and Neck surgery, an Otolaryngology Hospitalist, a Sleep Surgeon and community-based Otolaryngology Generalists to join our growing department.

Houston Methodist Hospital is a nationally recognized health care system affiliated with Weill Cornell Medical College. It is located within the heart of the Texas Medical Center, the largest medical center in the world. Recognized as one of the world's leading research and teaching institutions, Houston Methodist Hospital network delivers care throughout the Greater Houston Area with a hospital network that includes seven Regional Hospitals and a physician organization that includes a comprehensive network of providers and specialties. This combination of clinical service, research and academics ensures patients have access to the latest in treatments and technologies while providing the best in comprehensive patient care.

Houston Methodist Hospital is consistently ranked by US News and World Reports as the number one hospital in Texas and one of the top 20 hospitals in the country. This year, Forbes magazine ranked Houston Methodist Hospital the best employer in the state of Texas.

The Department of Otolaryngology-Head and Neck Surgery supports residency education for Baylor College of Medicine and the University of Texas.

We are searching for an individual at the rank of Assistant Professor or higher who possess outstanding clinical acumen, surgical skill, a record of academic accomplishments and a dedication to education.

Please direct your Letter of Interest and CV to:

BEST HOSPITALS USNews HONOR ROLL 2019-20

Mas Takashima, MD, FACS
Chairman, Department of Otolaryngology – Head and Neck Surgery, Smith Tower
6550 Fannin St., Suite 1723, Houston, Texas 77030
Email: mtakashima@houstonmethodist.org

utmb Health
Otolaryngology

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

These positions entail opportunities to participate in all aspects of clinical practice, as well as resident and medical student education. Candidates interested in pursuing comparative effectiveness clinical outcomes research are of particular interest.

In response to the rapid growth in our communities, the department has grown to now include 14 practitioners delivering care through all subspecialty areas of otolaryngology, a division of audiology, and a division of speech language pathology.

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

Facial Plastic/ Reconstructive Surgeon

FULL-TIME BE/BC
FELLOWSHIP TRAINED FACULTY

Laryngologist

FULL-TIME BE/BC
FELLOWSHIP TRAINED FACULTY

Rhinologist

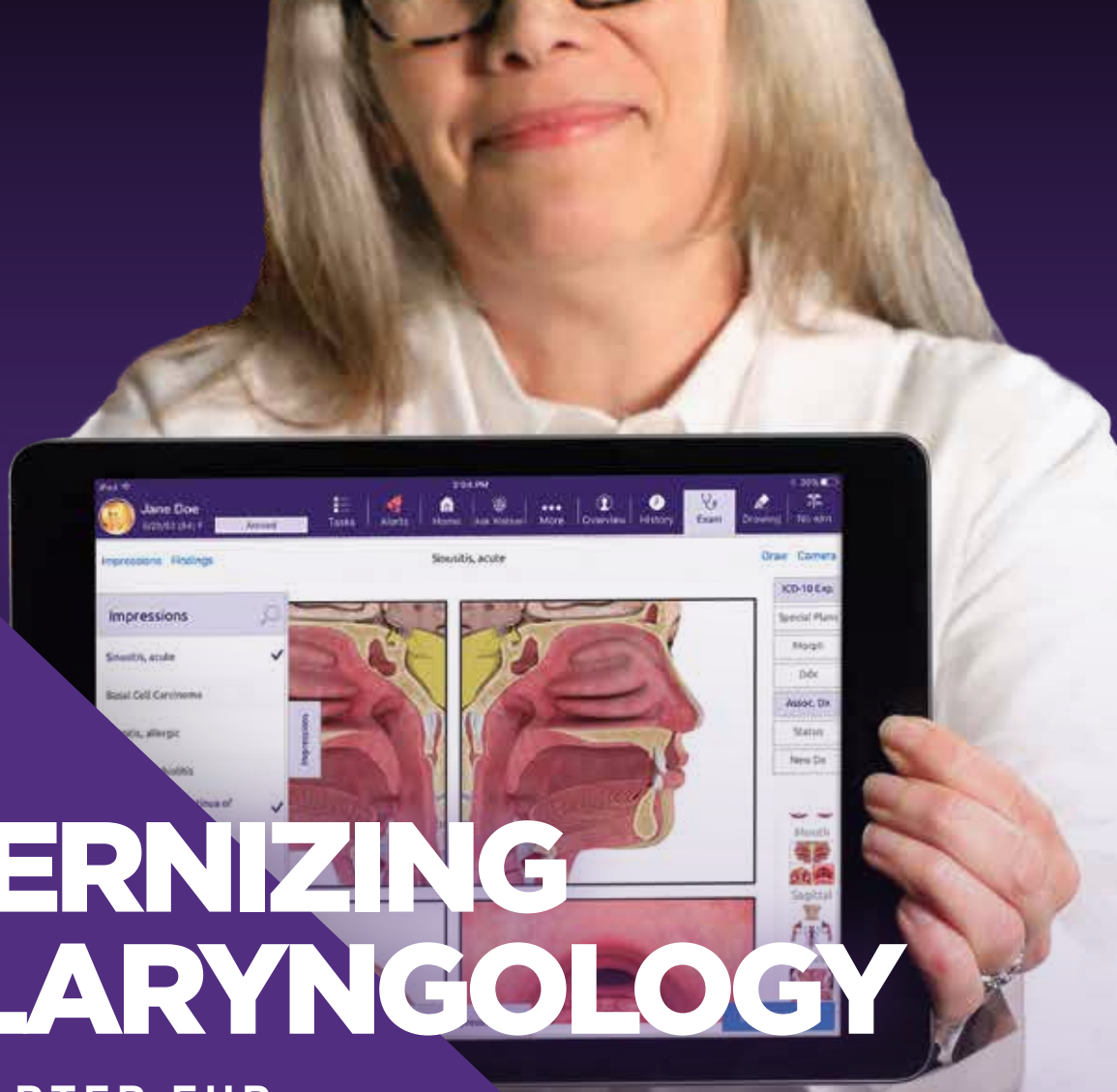
FULL-TIME BE/BC
FELLOWSHIP TRAINED FACULTY

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

Please direct your Letter of Interest and CV to:

Vicente Resto, MD, PhD, FACS
Physician Executive for Growth
Assoc. Chief Physician Executive for Faculty Group Practice
Chair, Department of Otolaryngology UTMB Health
301 University Boulevard, Galveston, TX 77555-0521

Email: varesto@utmb.edu
Phone: 409-772-2701



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