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bulletin

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

MAY 2020

Bringing Together the World of Otolaryngology

AAO-HNSF **2020** SEPTEMBER
ANNUAL MEETING **13-16**
& OTO EXPERIENCE BOSTON, MA
18



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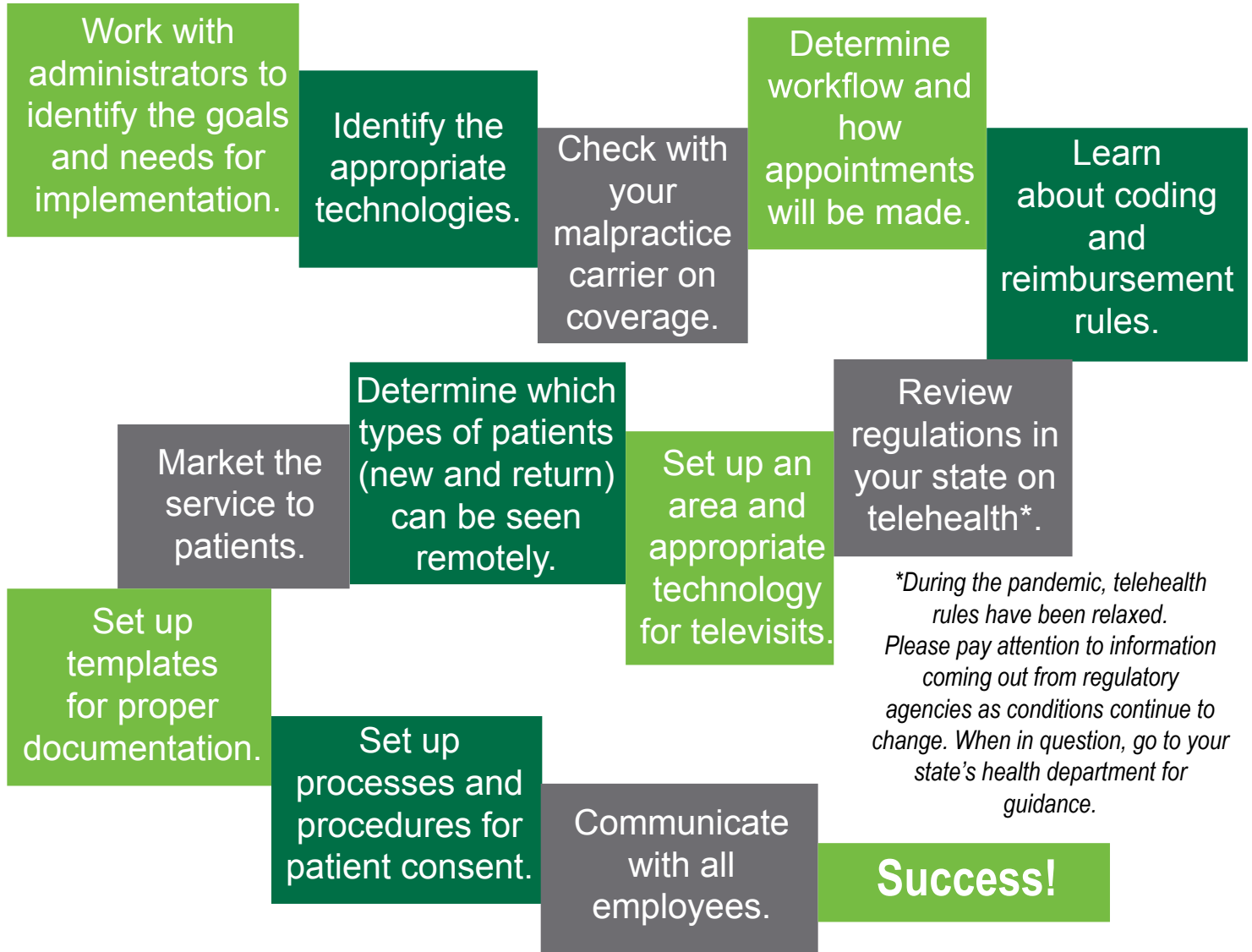
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May 2020

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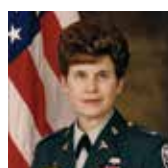
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A Time for Our Equanimity under Duress

Dear Friends and Colleagues,

My hope is that you and your families are healthy and safe as you continue to manage, communicate with, and care for your patients in some way. I realize that difficult times like these can bring us closer as a specialty and make us more poised and better positioned to understand, research, educate, empathize, interact, and work through the challenges caused by this global pandemic. I am moved by the way our leadership, staff, and many of our members have risen to the challenge and call by our Academy to contribute in some way to helping all of us in our specialty get through this crisis.

The energy, resilience, focus, and inner peace required of all of us at this time reminds me of a quote, “equanimity under duress,” associated with the much-admired surgeon, leader, and educator, LaSall D. Leffall, Jr., MD. Dr. Leffall passed away in May 2019 and had served in many capacities, including the chair of the President’s Cancer Panel, president of the American Cancer Society, and president of the American College of Surgeons. While he was professor and chair of the Department of Surgery at Howard University Hospital, he trained over 4,500 students and residents who, after spending time with him, understood the meaning of “equanimity under duress.” He gleaned this phrase from his appreciation of the essay by Sir William Osler, “Aequanimitas,” delivered to a group of newly “minted” medical students at their graduation. This phrase, which Dr. Leffall also bestowed upon one his many publications, alludes to the idea that we must be prepared to draw upon a sense of calmness and tranquility in the face of adversity and challenges that, in the moment, may seem beyond our control. Although I never worked alongside him or trained under him, my interactions with him let me know that he lived by this credo. Dr. Leffall gave a sense of reassurance and hope to his patients and great knowledge, inspiration, and direction to those he trained.

Unknowningly, our experiences and training

in our specialty have equipped us to manage the urgent, emergent, and time-sensitive decisions we are faced with daily, and we will emerge from the turmoil of this previously uncharted territory that surrounds us. In spite of any personal, physical, emotional, and financial losses we may suffer, we will come through this with a knowledge, growth, and understanding that will prepare us for a different way of doing things in the future. We will come through this with a greater sense of appreciation for those who we love, work with, depend on, and who depend on us. Although there are times we must be separated by physical distances, we are all bound by a tenacity, courage, and determination to come out of this stronger and together. It is important that segments of our new residents, graduating residents, and young physicians understand that our specialty will be ready to navigate the post-COVID-19 era as a profession.

Many of the positive things that we have gained from this experience are yet to be appreciated but might include that the resilience of the human spirit is without bounds when pushed to its limits. You are all to be commended for the leadership, hope, courage, and strength you demonstrate and share with your colleagues during this difficult time and hopefully pass on to your family, friends, and community.

This is a time when hopefully our mindfulness and wellness will no longer be just stored in our reserves for a crisis but will become an essential part of how we function daily as we still face the unknown. Whether it is time for introspection and meditation, time spent with our family, time for patient care, or time for understanding and appreciation, realize we should take no time for granted. Remember that together we can get through this time, finding solace in the eye of the storm, peace and tranquility in the midst of the storm, and inner calm as we exercise our “equanimity under duress.” Stay safe and healthy. **We Are One.** ■



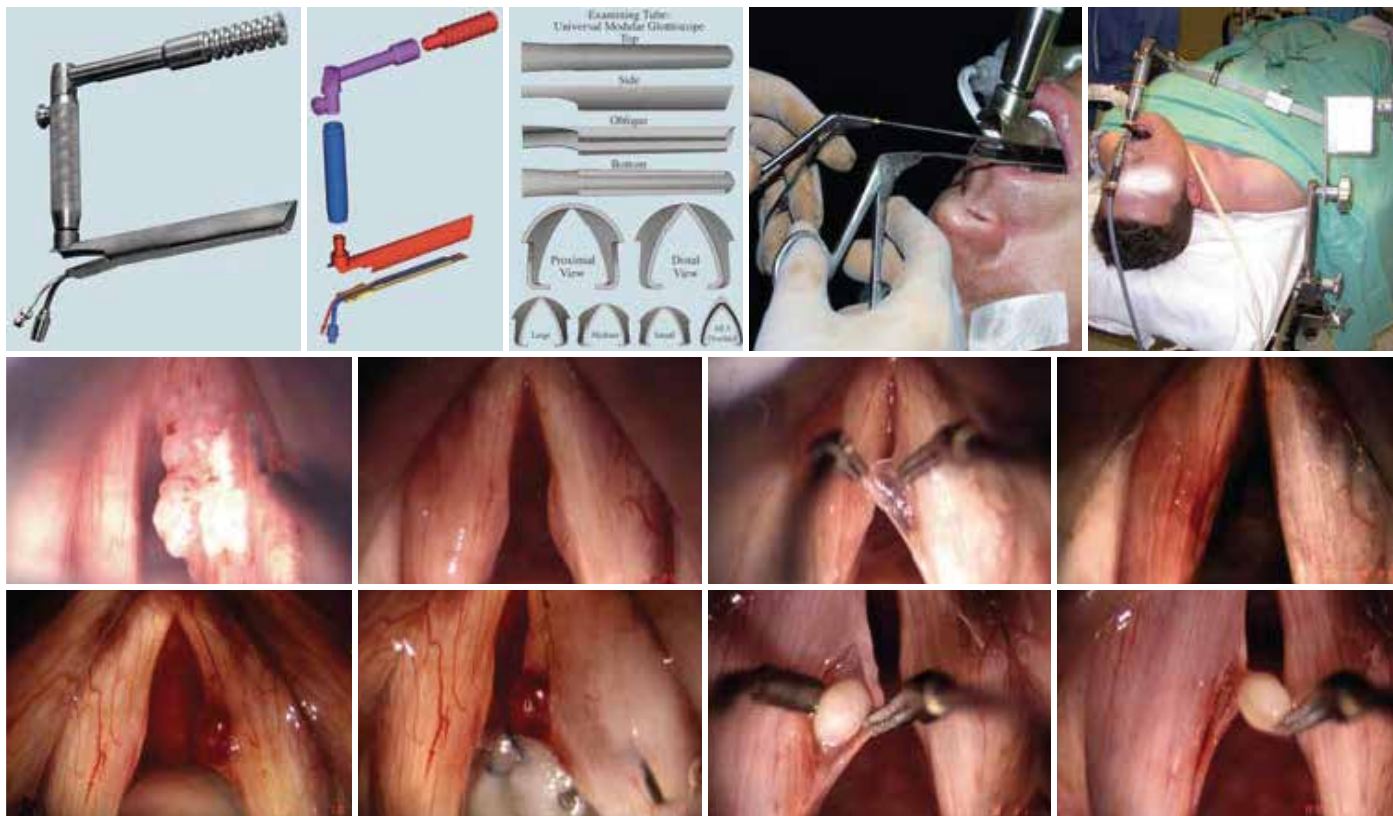
Duane J. Taylor, MD
AAO-HNS/F President

“Many of the positive things that we have gained from this experience are yet to be appreciated, but might include that the resilience of the human spirit is without bounds when pushed to its limits.”

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Our Otolaryngology Community: Collaborating and Sharing Experiences for Everyone's Mutual Benefit

Our May issue typically has been used to promote our Annual Meeting & OTO Experience as well as other upcoming events. Clearly, this is the most atypical May I have experienced during my four decades of treating otolaryngology patients. Most of the world is beginning to see some needed light at the end of the tunnel, and physicians are either incrementally returning to practice or planning for that eventuality in the near future. This month's column will borrow from the recent past, discuss the present, and preview what the future may hold for otolaryngology.

The COVID-19 pandemic has created unprecedented disruptive societal consequences that have resulted in extreme danger to populations worldwide and have necessitated public health measures dramatically changing the way healthcare is delivered. This has been particularly evident in the medical community that has been forced to deal with generalized fear within the population, supply and testing shortages, and evolving scientific knowledge. All of these have combined to greatly accentuate the normal stresses associated with the delivery of healthcare. Additionally, the financial consequences of the pandemic are weighing heavily on physicians and practices in all settings.

The Academy spent most of the last two months identifying, collating, organizing, and disseminating the most current information related to patient and healthcare community safety, disease diagnosis, COVID-19 statistics and progression, legislative and regulatory changes, and resources designed to survive the crisis. More recently, we are focusing on the process of "returning to practice" as we see many areas of the country on the downside of the curve and beginning to loosen restrictions. Our goal is to provide useful strategies to safely reinstitute normal office exams and procedures and elective outpatient and inpatient surgical care, all while maintaining the highest quality of care. The American College of Surgeons (ACS) released a guidance document detailing general principles to be considered as surgeons return to the operating room for non-emergent cases. This covers specific considerations for all five phases of surgical care over the broad spectrum of surgery. It will serve as the basis for otolaryngology to develop a specialty-specific transition plan back to the operating room including prioritization strategies as we evolve back to

full capacity. Our otolaryngology specialty societies have generously agreed to collaborate with the Academy committee structure so that we can produce a comprehensive and consistent list for otolaryngologist-head and neck surgeons to use in their offices, at ASCs, and in the hospital setting. This guidance will be helpful not only in re-operationalizing office practice, but also in negotiating operating schedules at your surgery center and hospital.

The societal disruption caused by the COVID-19 pandemic has stressed the general population and the entire healthcare community to exceptional levels. Fear of catching or spreading the virus, media reporting, shortage of resources, general and practice-specific economic concerns, and the loss of community have weighed heavily on everyone. During the isolation phase used to mitigate the rapid spread of COVID-19 for a prolonged period, it has become apparent how important community support and societal interaction are to a meaningful and satisfying life. The longer the isolation has persisted, the more I appreciate videoconferencing that at least enables you to have a greater semblance of spirit than a phone call. Simply allowing someone to describe what is going on with them adds immeasurably to the value of the meeting. I have been particularly moved by our podcast series on wellness, where our expert presenters have done a fabulous job on identifying cogent issues and measures available to deal with these situations. **Jo A. Shapiro, MD**, a participant on our first wellness podcast, has also written an article for this issue of the *Bulletin*. You can find "Peer Support: Taking Care of Ourselves and Each Other" on page 9.

Aside from losing the ability to practice medicine and the joy it brings, the cancellation of the majority of scientific meetings from mid-February through the summer has taken away some of the favorite education programs for physicians as well as the opportunity to renew existing friendships, make new ones, and exchange new ideas. There are many opportunities to obtain the CME necessary to maintain licensure and hospital privileging through a variety of virtual mediums. However, this year after physicians and the entire healthcare team have endured levels of stress and practice conditions that are unprecedented in the provision of routine care during their lifetimes, attending a meeting after we emerge from the



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

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COVID-19 pandemic crisis will offer much more than just the education opportunities. The personal exchange of experiences among friends will be uplifting and therapeutic as we strive to return to normal. Everyone's experiences will be based on a similar platform, but whether you are a student, a resident, an attending physician, a private practitioner, an employed physician, in the military, young or old, the personal occurrences etched in everyone's mind will be congenially shared to everyone's mutual benefit.

We are continuing the preparations for holding our 124th Annual Meeting & OTO Experience in Boston this September. **Drs. Wax and Chelius** led the Annual Meeting Program Committee through their first virtual program selection meeting and have identified a fabulous program with the flexibility to add late-breaking presentations as we emerge from the COVID-19 pandemic and establish new day-to-day practice norms. As a result of the multiple meeting cancellations around the world, the Academy's meeting in September will be a great opportunity to “Bring Together the World of Otolaryngology” to share scientific knowledge, personal experiences, and future plans. The camaraderie generated by new and long-standing friendships will be renewed and provide a solid support community that will last for years. Despite the advances in technology and the widespread availability of virtual meetings, the formation of new and the renewal of existing relationships on a personal level has immeasurable value.

In response to attendees' suggestions, we are moving our “Opening Ceremony” back to Sunday morning where it will mark the official beginning of the meeting. This year's opening ceremony will feature an outstanding presentation from our featured guest speaker, Joel Selanikio, MD, discussing his thoughts on the future of otolaryngology practice and how the pandemic influenced this evolution. He will also participate in an interactive Panel Presentation with Academy leaders and an interactive discussion with attendees as we explore the topic in more detail. For those interested in medical history, there will be a premier event at the Ether Dome and adjoining museum on Monday evening that will feature insightful presentations including the resident competition for best paper. I encourage you to thoroughly peruse this month's *Bulletin* for a complete review of the details of the meeting.

In the wake of the tremendous fallout from the COVID-19 pandemic that was mostly negative, I find great optimism and encouragement from the ability of society at all levels to focus on a common problem with a collaborative and productive resolve

to address this millennial event. This was particularly true in the medical community, which was faced with total disruption of normal practice patterns, initial severe shortages of supplies for protection, diagnosis, and treatment, all while being at substantial risk of infection yourselves and facing considerable economic consequences. Physicians and other healthcare workers were often placed into situations outside of your normal areas of expertise.

The rapid response in identifying and prioritizing not only the immediate concerns and needs raised by the pandemic, but also the short-term, intermediate, and long-term ramifications was made possible by marshaling the resources available from many sources, not the least of which was the medical association community. The willingness to share information and best practices transcended national and state borders, specialty designations, and levels of training. These efforts predominantly involved patient and provider safety, accumulating real-time scientific information, education and training concerns, and short-term economic issues. There is ongoing investigation into the breadth of consequences that will result from this event. Equally important has been the aggressive, unified advocacy efforts on behalf of all healthcare providers and their patients. These efforts resulted in unprecedented legislative and regulatory policies that changed the course of the disease and benefited providers and patients alike. Make no mistake, there is still much to be done, but these actions set the stage for further recovery.

It has been particularly gratifying to work hand-in-hand with our specialty societies within and outside of the otolaryngology family to produce education and scientific information that is consistent and that has and will continue to affect policy favorably. For example, the Society of Critical Care Medicine opened their tool “Critical Care for Non-ICU Clinicians” to all physicians for no cost and proved invaluable for those reassigned to these areas. And the Academy's initiative on anosmia was instrumental in the CDC's decision to add anosmia as a sentinel symptom of the coronavirus. The COVID-19 Anosmia Reporting Tool drew responses from multiple specialties across the world. Learn more about those efforts on page 8.

As long as “**We are One,**” both as otolaryngologists and as a medical community, recent evidence shows that we can accomplish a great deal for our specialty, profession, and the patients we serve. Your Academy will continue to actively work with you to recognize and accomplish your goals. Thank you for all that you do! ■

We Are ne

AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY

Global Otolaryngology Community Comes Together in the Face of COVID-19 Pandemic

Note: This article reflects the current COVID-19 situation as of April 23, 2020. The fast-changing pace of information related to this pandemic may not all be reflected in this column due to the Bulletin's publication schedule.

James C. Denny III, MD

AAO-HNS/F Executive Vice President and CEO

The healthcare community has been thrust into an unprecedented situation during the COVID-19 pandemic that has tested us mightily as we deal with supply shortages, the lack of adequate reliable testing, incomplete knowledge of COVID-19 transmission, and significant risks to those providing care. This has created extraordinary stress on our specialty as we strive to integrate necessary patient care while promoting public health measures to protect our communities, families, and friends, and at the same time struggling to maintain our practices. During this critical time, our members' commitment to excellence in patient care through engagement with the Academy's communications and recommendations has been remarkable and has made a difference.

I want to extend my sincere appreciation and admiration to our amazing physician

community and the healthcare teams they work with for their dedication to research and best practices and incorporating them in the current rapidly changing scenario worldwide. Your Academy staff and leaders are dedicated to identifying applicable guidance documents to serve you, your practices, and the public. It is gratifying to be a small part of your team and observe how quickly you are accessing resources we are providing and adapting them to your personal situation. From new COVID-19 related Position Statements focusing on tracheotomy, elective surgery, and urgent and nonurgent patient care, to research tools such as the [COVID-19 Anosmia Reporting Tool](#), our new podcast series, financial relief resources, and legislative and regulatory updates on the [AAO-HNS COVID-19 Resource page](#), we thank you for looking to your Academy during these challenging times.

Your participation in the AAO-HNS community and the otolaryngology-head and neck surgery community worldwide has developed a reliable and trusted circle of peer-to-peer connection. We have seen this in extraordinary engagement on [ENTConnect](#), providing support to each other, triggering Academy policies and position statements, sharing resources, and just being a sounding board for what you as

individuals and the collective community are experiencing. In the last two weeks, we have seen participation in ENTConnect grow by 262 percent. It is heartening to see that you are consuming and absorbing resources. The website traffic is up 370 percent from March 18 - April 11, with increased attention to the [AAO-HNS COVID-19 Resource page](#), Academy Position Statements related to COVID-19, and the research accepted for publication in *Otolaryngology-Head and Neck Surgery*. The [AAO-HNS COVID-19 Podcast Series](#) episodes have been downloaded over 11,500 times. These analytics tell us that this information is useful to you and your practice. This engagement with the Academy also extends to social media as we use various ways to get you the information you need. The Academy voice has been heard and further extended by exceptional media coverage around the world of our position on Anosmia, Hyposmia, and Dysgeusia Symptoms of Coronavirus Disease.

We urge you to continue being a part of the connected community that is your Academy. Your engagement is what pushes us to make sure that we are providing you the resources you need as a measure of support during this critical time. As always, **We Are One** and please stay safe! ■



OTO Journal

COVID-19 ACCEPTED PAPERS

Otolaryngology–Head and Neck Surgery has accepted several COVID-19-related papers for publication. In an effort to expeditiously distribute this research, the authors have agreed to share their accepted manuscripts. A list of these manuscripts as well as those that are now published online can be found at <https://www.entnet.org/content/oto-journal-covid-19-accepted-papers>.



In March, the Academy launched a new podcast series specific to COVID-19. The series provides peer-to-peer connection on COVID-19 pandemic related topics. Episodes are continually being added to the series. Download the FREE official AAO-HNS podcast app frequENTcy to receive immediate access to the release of all COVID-19 podcasts. The app is available in the Apple Store, Apple Podcasts App, Google Play, and for Spotify subscribers. Download now at <https://www.entnet.org/content/frequency-podcast-app>.

As of April 23, 2020, the following episodes are available in the COVID-19 Podcast Series:

- Episode 1: Patient Safety
- Episode 2: CARES Act
- Episode 3: Epidemiology
- Episode 4: Business Topics and Practice Workflows
- Episode 5: Telemedicine
- Episode 6: ENTs Personal COVID-19 Experiences: Managing Your Wellness
- Episode 7: Ethics
- Episode 8: What to Expect as We Resume Practice: Learning from Katrina
- Episode 9: Reopening Your Practice (Private Practice Focus)

Anosmia and Dysgeusia: Research Effecting Change

The Centers for Disease Control and Prevention added “new loss of taste or smell” on April 17 to the list of symptoms that may appear 2-14 days after exposure to the virus on their Symptoms of Coronavirus web page.

This action follows the Academy’s extensive efforts on this issue, which include a public statement on March 22, the launch of a reporting tool for data collection on March 26, public outreach through substantial media coverage, and the publication of initial findings from the reporting tool in *Otolaryngology–Head and Neck Surgery* on April 10. This was all done in a few short weeks demonstrating the strength of the otolaryngology community voice.

Short Scientific Communication

COVID-19 Anosmia Reporting Tool: Initial Findings

Authors: Rachel Kaye, MD, CW David Chang, MD, Ken Kazahaya, MD, MBA, Jean Brereton, MBA, and James Denny, MD https://www.entnet.org/sites/default/files/uploads/kaye_covid-19_anosmia_reporting_tool_initial_findings.pdf

According to the authors, “**We analyzed the first 237 entries which revealed that anosmia was noted in 73% of subjects prior to COVID-19 diagnosis and was the initial symptom in 26.6%.**” Our findings suggest that anosmia can be a presenting symptom of COVID-19, consistent with other emerging international reports. Anosmia may be critical in timely identification of individuals infected with SARS-CoV2 who may unwittingly be transmitting the virus.”

The AAO-HNS continues to collect data and further analysis will be done. Thank you to the members of the AAO-HNS Patient Safety Quality Improvement and Infectious Disease Committees as well as other involved Academy members for putting into action the necessary tools and research to effect change.

AAO-HNS Statements

The following statements have been issued by the Academy during the weeks since the COVID-19 pandemic:

- Position Statement: Tracheotomy Recommendations During the COVID-19 Pandemic (REVISED APRIL 2, 2020)
- AAO-HNS Responds to CMS Statement on Adult Elective Surgery and Procedures Recommendations (UPDATED: March 26, 2020)
- Position Statement: Otolaryngologists and the COVID-19 Pandemic (March 23, 2020)
- Anosmia, Hyposmia, and Dysgeusia Symptoms of Coronavirus Disease (March 22, 2020)
- AAO-HNS New Recommendations Regarding Urgent and Nonurgent Patient Care (March 20, 2020)

MORE COVID-19 RESOURCES

Please bookmark the AAO-HNS Coronavirus Disease 2019: Resources web page for access to the latest information and tools, including:

- State and federal financial relief information
- Updates from the CDC, CMS, FDA, NIH, and other federal agencies
- Information for you, your practice, and your patients
- Shared clinical research and news from around the specialty

Content is being added frequently to address the varying and timely needs of our global otolaryngology community. <https://www.entnet.org/content/coronavirus-disease-2019-resources>

Peer Support: Taking Care of Ourselves and Each Other

Jo A. Shapiro, MD

Much of our identity is wrapped up in the culture of our profession as otolaryngologists, surgeons, healers. This is a good thing. It doesn't negate our other core identities: mom, wife, daughter, sister, friend, activist, etc. We are all a synthesis of these various parts of our whole being.

And what an honor to be a healthcare provider and specifically an otolaryngologist. People trust us with their lives. We affect people on such deep levels. It takes so long to acquire the science and art of being a master in our field. We're always learning and growing. It's a lifelong journey that we are proud to be on.

While embracing these unique and rewarding aspects of our professional culture, we need also to wake up to the dark side of our culture. This dark side is not unique to our specialty. In my experience, both the positive and negative aspects of medical culture are universal: across specialties, disciplines, types of healthcare organizations, and even across national and international settings. Simply put, the culture of medicine does not value our well-being. We are expected to be immune to our own and our colleagues' physical, mental, and emotional suffering. Self-care is viewed as selfish. Denial of our needs is seen as both expected and heroic.

To be clear, much of the time we need to put patients' needs above our own. There is so much work to be done, especially now. But we cannot ignore our own humanity indefinitely. Doing so has been a major factor in allowing burnout to take root and flourish. Doing so has contributed to the appalling rates of physician suicide. We need a different approach. Right now.

Based on my years of experience in collaborating with others on promoting the well-being of physicians and other healthcare providers, I have the following observations.

We need to be aware, both personally and as a community of professionals, of the negative cultural biases that are ingrained in all of us, because the only way to overcome biases is to acknowledge their presence and decide to act differently.

We believe that sleep deprivation doesn't affect us the way it does nonsurgeons; we are trained to power through, and we are fine

with less than six hours of sleep each night. Get acquainted with the sleep literature: Even short-term sleep deprivation can cause cognitive impairment.

Depression, anxiety, and other mental health disorders are at least as common for us as they are in the general population. Substance use disorder is a disorder, not a moral failing. All of these are treatable. In the past, it was extremely difficult to get help without permanently jeopardizing one's career. Currently, we can be treated in a way that protects both us and patients—under the auspices of experts in physician health organizations.

We are each at risk for experiencing acutely stressful events at some point in our careers: errors, being named in a lawsuit, a bad patient outcome unrelated to adverse events, etc. Errors are particularly challenging for us. We are taught that providing the highest-quality patient care is dependent upon our perfect performance. Yet safety science teaches us that eliminating human error is an impossibility. No matter how smart, well-trained, and proficient we are, humans are wired to make errors. Patient safety cannot be predicated on the impossibility of perfect performance. Instead, patient safety depends on decreasing the chances of our making individual errors, understanding what conditions may set us up to make errors, and then applying both personal and systems accountability to improvement and learning. This is the basis of a safety culture as opposed to the shame-and-blame culture that most of us trained in and have inadvertently perpetuated.

The COVID-19 pandemic is a massive challenge for us as a society and as a profession. The specific challenges are legion: distribution of PPEs, testing capabilities, decisions regarding what the new standards are for care, ethical challenges regarding who gets what care, and many more. Associated with these challenges is their effect on us—sleep deprivation, overwork, and the myriad human emotional responses that may include fear, anger, anxiety, moral distress, and helplessness.

What is a way forward given our culture and the challenges we face in practicing our profession? I believe there are several core principles:

1. Value what we do. As I have said on podcasts, webinars, virtual town halls, and peer support training sessions, thank you

for all you do. Every single one of you. It is remarkable and beautiful.

2. Acknowledge our pain. We suffer because we are compassionate and vulnerable, not because we are weak or selfish. Let's acknowledge our emotions so that we can manage them rather than be destroyed by them. Use peer support to allow ourselves to speak about our occupational distress with our colleagues in a safe environment. Let's acknowledge our mental health and physical challenges so we can get expert treatment. Stay attuned to your own physical, emotional, and mental health.

3. Rely on our professional collegial community. Community will get us through this crisis and through all the challenges in our profession. Organizations such as the Academy of Otolaryngology–Head and Neck Surgery, the American College of Surgeons, and the American Medical Association are all working to advocate for us and connect us with knowledge and expertise to deal with COVID-19 and other major crises. Our local healthcare teams need our guidance and appreciation for the work they do. And they in turn will support us. Create processes for checking in with the team, whether daily or weekly. Laura Rock, MD, for example, has done pioneering work on clinical debriefings. The Center for Medical Simulation created a related process for daily briefings and debriefings. Make sure such processes explicitly integrate some form of peer support for emotional responses to current challenges.

4. Individual peer support is key. Don't put the burden on your colleague to ask for help; they are highly unlikely to do so because of the cultural stigma. Offer your colleague some time to just decompress. The essence of peer support is reaching out to your colleague to offer your loving presence. Help them identify what healthy coping mechanisms they can use. Normalize and validate their negative emotions. Without minimizing their emotions, remind them also of how much good they do.

We can't fix each other's pain, but we can go a long way to helping each other through the pain. ■

See the online version of this article for a complete list of references used.

■ at the forefront

Information, resources, and updates in this section

Reg-ent Is the MIPS Reporting Solution of Choice for Otolaryngology-Head and Neck Surgery: Here's Why

Free eCourse: Telemedicine during the Pandemic

Age-related Hearing Loss Quality Measures

Clinical Consensus Statement

Education Opportunities from OTOSource

Humanitarian Travel Grant Recipient Provides ENT Care in Ghana

➔ READ MORE ONLINE

Humanitarian Travel Grant Recipient Provides ENT Care in Ghana



Reg-ent Is the MIPS Reporting Solution of Choice for Otolaryngology-Head and Neck Surgery: Here's Why

In addition to serving multiple functions as the clinical data registry for otolaryngology-head and neck surgery, Reg-ent is also utilized by members to submit data to the Centers for Medicare & Medicaid Services (CMS) per the requirements of the Merit-based Incentive Payment System (MIPS). Designated by CMS as a Qualified Clinical Data Registry (QCDR), Reg-ent can accommodate required reporting for three of the four MIPS 2020 performance categories: Quality, Promoting Interoperability (PI), and Improvement Activities (IA). Members participating in Reg-ent submit data to CMS for one, two, or all three of the performance categories and can do so at the individual clinician or practice level.

Through Reg-ent's advanced, user-friendly technology platform, registry participants have access to a customizable and interactive Reg-ent dashboard that provides a **visual representation of quality performance data at the provider and practice levels** and offers feedback opportunities to physicians and nonphysician providers so they may compare their performance with other clinicians in the registry at a national level. These capabilities support MIPS Quality performance category reporting in addition to allowing Reg-ent participants to monitor patient care and outcomes, identify gaps in care, and assist

with implementation of evidence-based changes in care.

The Reg-ent MIPS module within the Reg-ent dashboard is configured in alignment with the scoring calculations and reporting requirements as outlined by CMS for MIPS 2020. The Reg-ent module provides participants with an **estimated MIPS score for each performance category** based on reporting selections and practice-/clinician-specific details that impact scoring.

Reg-ent currently contains 57 quality measures, all of which can be reported for MIPS 2020. Reg-ent includes 17 QCDR otolaryngology-specific measures developed by the AAO-HNSF available only in Reg-ent and 40 publicly available Quality Payment Program (QPP) measures that have been identified as applicable to AAO-HNS members.

Members who participate in Reg-ent are directly supporting the specialty through the contribution of data to the registry's data repository specific to otolaryngology-head and neck surgery. It is the **collective data in Reg-ent that empowers our specialty to determine the future of otolaryngology care**—not only to define quality patient care and outcomes, but also to demonstrate the value of the care we provide.

Interested in learning more? Visit www.reg-ent.org or contact reg-ent@entnet.org. ■



Free eCourse: Telemedicine During the Pandemic

Free for members and nonmembers: This timely new course provides a guide for immediate implementation of telemedicine in your practice in response to the COVID-19 pandemic. This course was developed in collaboration with the Practice Management Education Committee and Telemedicine Committee. Learn more at <http://academyu.entnet.org/>. ■



Age-related Hearing Loss Quality Measures

Two Qualified Clinical Data Registry (QCDR) measures related to geriatric otolaryngology were developed by the Age-related Hearing Loss Measures Development Group (MDG). These quality measures were created for the diagnosis and treatment of age-related hearing loss, including bilateral presbycusis and symmetric sensorineural hearing loss in older adults. They are available through the Reg-entSM registry:

- AAO16 - Age-related Hearing Loss: Audiometric Evaluation

- AAO17 - Age-related Hearing Loss: Advanced Diagnostic Imaging of Bilateral Presbycusis or Symmetric SNHL

These quality measures are used to track patient care, connect outcomes with processes, and meet third-party payer requirements, such as the Merit-based Incentive Payment System (MIPS). By utilizing these quality measures through Reg-ent, you can track performance and benchmark against your peers.

To view the measure specifications and learn more, visit www.entnet.org/2020-measures. ■



Education Opportunities

OTOSource, a single-source online repository for otolaryngology education, covers numerous topics from allergies to sinonasal disease in the senior population. Review conditions and treatment of geriatric patients through study guides and surgical videos on this free platform at www.otosource.org. ■



► **Update Your Find an ENT Profile by Logging in at Entnet.org**

Clinical Consensus Statement: Ankyloglossia in Children

The AAO-HNSF Clinical Consensus Statement (CCS): Ankyloglossia in Children was published online in *Otolaryngology-Head and Neck Surgery* on April 14. Read the CCS now at <https://journals.sagepub.com/doi/full/10.1177/0194599820915457>. ■

HUMANITARIAN TRAVEL GRANT

Humanitarian Travel Grant Recipient Provides ENT Care in Ghana

Janet Lee, MD, received a Humanitarian Travel Grant to provide ENT care to citizens in the Cape Coast Teaching Hospital (CCTH) in the central region of the Republic of Ghana in West Africa. Along with the nonprofit organization One Less Drop and a group spearheaded by Jeremy D. Meier, MD, of the University of Utah, and Peter Appiah-Thompson, MD, of CCTH, Dr. Lee worked to see patients in a screening clinic and then to complete approximately 20 surgeries over a four-day period.

“While the majority of these surgeries were for otologic disease, patients with choanal atresia, branchial cleft anomalies, and various ENT foreign bodies were also treated,” Dr. Lee said. “It was a joy to simultaneously provide care to those in need and to help give others the skills to do so in our absence.” ■



➔ **READ MORE ONLINE**
Longer article available



American Society of
Geriatric Otolaryngology

Geriatric-Specific Otolaryngology Approaches

Robert T. Sataloff, MD, David E. Eibling, MD, Michael M. Johns III, MD, Karen M. Kost, MD, Brian J. McKinnon, MD, MBA, MPH, Kourosh Parham, MD, PhD, Steven M. Parnes, MD, G. Carl Shipp, MD, and Ozlem E. Tulunay-Ugur, MD, for the ASGO Executive Council

For decades, pediatric otolaryngologists have taught that children are not just small adults and that their care requires adopting unique approaches. It has become clear that geriatric patients are not just old adults but individuals who require diagnostic and therapeutic strategies different from those used for younger adults. Caring for them optimally requires understanding their physiology; the otolaryngological and surgical consequences of systemic disease, polypharmacy, age-related sensitivities to medications, effects of cognitive impairment on treatment selection; and the many other issues unique to the elderly adult. A comprehensive review for otolaryngologists was copublished by Thieme and the American Academy of Otolaryngology–Head and Neck Surgery Foundation (AAO-HNSF) in the book *Geriatric Otolaryngology* (2015). The book highlights geriatric otolaryngology issues, including the science of aging, epidemiology, geriatric syndromes, outpatient care and outpatient surgery risks, age-specific preoperative evaluation, hearing loss, tinnitus, dizziness, sinonasal disease, taste and smell disorders, allergy, dysphonia, dysphasia, sleep disturbance, facial plastic surgery, oral cavity disorders, cutaneous malignancies, head and neck cancer, and cognitive assessment.

Acquiring such knowledge is important for otolaryngologists practicing in the 21st

century. In 2006 500 million people in the world (8 percent) were 65 or older, and by 2030 the number is expected to be 1 billion (12.5 percent). Predictions indicate that 20 percent of the U.S. population will be 65 or older by 2030, of which 14 percent will be 85 or older. The number of people 100 and older has doubled every decade since 1950. Of people born now, one in 20 males and one in 10 females are expected to live past age 100. Hence, an increasing number of our patients will be geriatric, and we need to prepare to care for them well.

In addition to an increase in the number of geriatric patients, we also must consider the increasing number of geriatric doctors. The American Society of Geriatric Otolaryngology (ASGO) has addressed this important topic during several of its meetings, particularly with panels such as “The Aging Otolaryngologist” and “Retirement and Life after for an Otolaryngologist.” There have been publications on the aging physician in our literature, as well. It is clear that there is no relationship between an older physician’s self-assessment of cognitive function and objective assessment. However, objective measures to assess physician competence that correlate with patient outcomes are lacking. Yet, physicians are working longer. So, methods to predict decrease in performance are needed badly, but current approaches lack evidence that test results correlate with the clinically relevant information sought.

Many older otolaryngologists recognize when it is time to slow down. However, neither our residencies nor most of our institutions provide training on how to plan

for successful retirement by addressing finances, physical changes, psychosocial changes, transition planning, and other topics. Hospitals and universities could help with such training and by offering transition flexibility, resisting ageist stereotypes, minimizing part-time work barriers, creating post-retirement career opportunities (teaching, peer support, and others), and developing education programs for physicians of all ages that highlight the importance of retaining older physicians in the workforce. Older physicians not only provide invaluable knowledge and experience, but they are often responsible for a substantial number of referrals and for institutional reputation. Moreover, it commonly takes more than one doctor to replace retiring “old-timers”; institutions therefore have practical incentives to become involved.

ASGO, the AAO-HNSF Geriatric Otolaryngology Committee, and other organizations are working hard to increase knowledge and raise awareness regarding aging issues important to our patients and our workforce. We encourage including geriatric content in our training programs and examinations. Involvement of all otolaryngologists and allied healthcare personnel is welcomed and encouraged. Organizations such as ASGO, the AAO-HNSF, and the American Board of Otolaryngology – Head and Neck Surgery should take the lead in ensuring that all otolaryngologists develop the competencies necessary to manage geriatric patients optimally in the coming decades. ■

See the online version of this article for a complete list of references used.



Uncertainty and Its Impact on the Young Otolaryngologist

David S. Cohen, MD, YPS Chair

Being a young otolaryngologist is simultaneously incredibly exciting and utterly terrifying even on a routine day-to-day basis. Keeping patients alive with precarious medical conditions, mastering your craft, building your practice, and discovering your preferences all while traversing the complex landscape of medicine in America is difficult in and of itself. Now, add in the global pandemic of COVID-19, and the balancing act of keeping a practice open and running is even more destabilized.

There are specific trials and tribulations that come with being a young surgeon. You realize that what was once dogma in your training may not be common practice in your present setting. Surgical techniques are tried and tested, ultimately filtering into a chimera of your most important influences mixed with current research and trends. You collect mentors along the way in various stages of career and reach out to them for expert consultation or a shoulder to lean on after a hard day, often virtually. Compound this with the daily responsibilities of life—finding a place to live, starting or expanding a family, or learning how to protect your investments—it's no small feat this life we choose to live, and uncertainty becomes a feeling all too familiar.

And yet despite juggling these

responsibilities, our focus remains on one choice that we made not so long ago: to care for our patients as if they were our own family. Many of us will be placed into situations that threaten our opportunity to practice. Whether it is business closures affecting our ability to pay staff or a lack of personal protective equipment that could expose our physicians to a heightened risk of contracting COVID-19, we approach these obstacles willingly but with uncertainty. Uncertainty that we may be redeployed to practice medicine outside our typical scope. Uncertainty that we may lose the ones we love. Uncertainty that life may never return to “normal.”

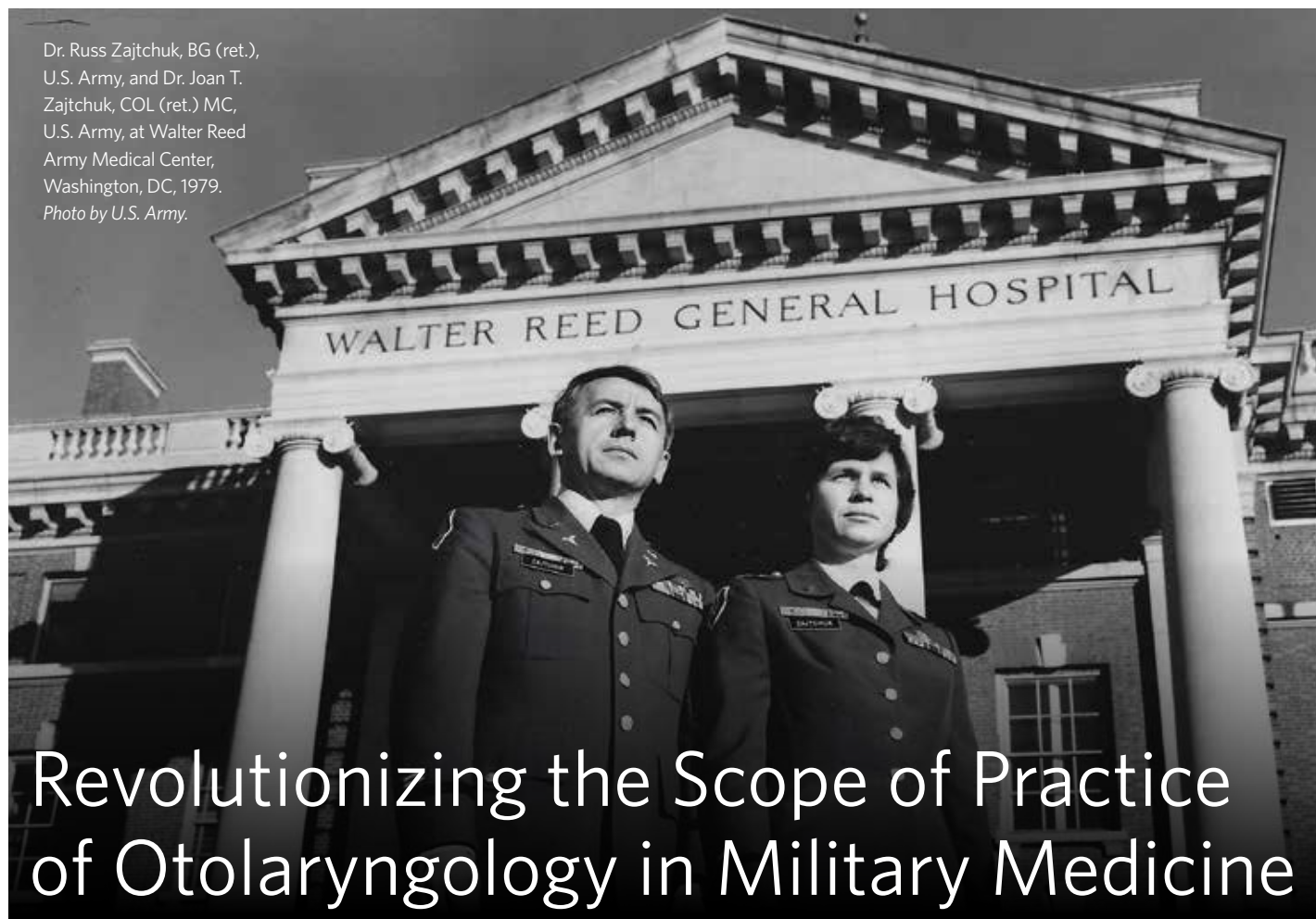
But with the uncertainty comes the recognition that we have already conquered similar adversities. It's important for us to come together for resiliency and support. It's important to have a community where hardships and stressors can be discussed and the tools to conquer them disseminated broadly and rapidly. Despite social distancing, there is a certainty that our profession will endure. Our patients will still need treatments, and our responsibility to their care reaffirms our decision to be an otolaryngologist, even if it means a little more precaution regarding aerosols. So for now, we stomach the uncertainty we've become acclimated to and await the uncertainty that tomorrow brings—it is, after all, familiar. ■

“

...our focus remains on one choice that we made not so long ago: to care for our patients as if they were our own family.

”

Dr. Russ Zajтчuk, BG (ret.),
U.S. Army, and Dr. Joan T.
Zajтчuk, COL (ret.) MC,
U.S. Army, at Walter Reed
Army Medical Center,
Washington, DC, 1979.
Photo by U.S. Army.



Revolutionizing the Scope of Practice of Otolaryngology in Military Medicine



Dr. Joan T. Zajтчuk, Deputy Commander of
Walter Reed Army Medical Center, Washington,
DC, 1994. *Photo by U.S. Army.*

Dr. Joan T. Zajтчuk, COL (ret.) MC, U.S. Army, joined the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) when she returned from the Vietnam War in 1972. “My career trajectory in academic medicine after my residency was uncertain,” she explained. “A military career was unusual for a woman. Women doctors were not drafted, so I had to volunteer. This carried a mandatory two-year contract. I joined the Army to be stationed in Vietnam along with my husband who also volunteered. To my knowledge, I was the only woman surgeon in the Army during the war.”

In 1967, Dr. Zajтчuk was also the first female otolaryngology resident selected by Dr. John Lindsay, then chair of the Otolaryngology Section at the University of Chicago. As a third-year resident,

with a year and a half left to complete her training, she personally met with the president of the University of Chicago to help stop a move to jeopardize the school’s well-respected otolaryngology program.

“During this period, there was a bold political move by the Department of Surgery to divert trauma and head and neck tumor cases away from otolaryngology,” she said. “All residents were required to have a certain surgical case load at the end of their training; without that case load, the program would lose accreditation completely. Morale was quite low, so I decided to engage with the president directly. As you can imagine, quite a few comments were made about ‘this pushy woman resident,’ but I helped reverse the impending dissolution of the residency training program.”

In Vietnam, Dr. Zajtchuk was assigned to 24th EVAC Hospital in Long Binh and the 3rd Field Hospital in Saigon. “In my off-duty time, I did volunteer teaching at a hospital in Saigon, and worked closely with many civilian Vietnamese doctors. I received the Silver Health Medal from the Minister of Health of the Republic of Vietnam.

“My husband and I stayed in the military because of our war zone experience; we saw that we could provide service to our country. We realized the great sacrifices that were made by these young draftees, the young men who were fighting that war, and we appreciated their service to our country.” Dr. Zajtchuk’s husband is Dr. Russ Zajtchuk, BG (ret.), U.S. Army.

Returning from service in Vietnam, she was assigned to Fitzsimons Army Medical Center in Denver as assistant chief, Otolaryngology Service, discovering that “there were less than one percent of women practicing in the specialty.” There, she was promoted to the rank of lieutenant colonel, and served as Assistant Clinical Professor of Otolaryngology at the University of Colorado School of Medicine.

In 1977, Dr. Zajtchuk was assigned to Walter Reed Army Medical Center in Washington, DC, where she would spend the next 17 years of her career. She was promoted to the rank of colonel, and held the positions of Chief and Program Director, Otolaryngology/Head and Neck Surgery Service, Department of Surgery (another first for women in military medicine); Professor of Surgery and Chair, Division of Otolaryngology, Department of Surgery and Associate Dean for Academic Affairs (Uniformed Services University of the Health Sciences) and Deputy Commander and Director of Graduate Medical Education; and much more.

Using her background in the military, Dr. Zajtchuk worked in countries around the world, particularly in Central and South America, to develop medical exchange programs for physicians and other personnel to train at Army Medical Centers in the United States. She commanded the medical element of Joint Task Force Bravo,

History of Women in Otolaryngology

The AAO-HNS has been working quietly behind the scenes over the past several months to curate a collection of artifacts and create a historic timeline showcasing the significant impact women have made in the specialty.

This History of Women in Otolaryngology exhibit will reside in the John Q. Adams Center, the museum on the top floor of the Academy headquarters. A number of women pioneers in otolaryngology will be honored in the exhibit, including Joan T. Zajtchuk, MD, who has played an incredible role leading the Academy’s efforts in developing this exhibit. More information about this exhibit will be forthcoming.

the hospital caring for U.S. troops in Honduras, and helped establish the military humanitarian assistance program.

“Now, whenever Armed Forces are deployed around the world, a medical element will deploy with them to conduct humanitarian assistance. We worked with doctors, nurses, dentists, even veterinarians to set up clinics in very remote areas to teach people about elementary healthcare needs. Had I not had that military experience, I could not have accomplished anything like this.”

Dr. Zajtchuk was an early innovator in the digital revolution. As Deputy Commander at Walter Reed in 1991, she developed the first telemedicine prototype that was soon adopted to provide tertiary care expertise for deployed Army troops worldwide. Her strategic vision—providing healthcare “anytime, anywhere”—became the template for the Triservice healthcare mission.

In 1994 she was named Special Assistant to the Army Surgeon General, and served a total of 25 years of active duty in the Medical Corps. At retirement in 1996, she was awarded the Distinguished Service Medal for her exceptionally meritorious service in positions of great responsibility. Returning to Chicago in 1998, she became Associate Dean, Medical Student Programs at Rush Medical College, and retired as Professor Emeritus, Department of Otolaryngology and Bronchoesophagology.

In addition to numerous civilian honors and appointments, Dr. Zajtchuk received the AAO-HNS Foundation Award for Distinguished Service in 1985, and the first AAO-HNS Humanitarian Award in 1990. She has been decorated for her service by the countries of Vietnam, Honduras, Poland, and Oman. Her U.S. military honors and medals include (but are not limited to):

- Distinguished Service Medal
- Legion of Merit with 1st Oak Leaf Cluster
- Bronze Star
- Defense Meritorious Service Medal
- Meritorious Service Medal with 1st Oak Leaf Cluster
- Army Commendation Medal

Throughout her career and particularly as Otolaryngology Consultant to the Army Surgeon General, Dr. Zajtchuk sought to expand the scope of practice within the specialty. “This was a time when our residency program directors nationwide were faced with another political battle to keep head and neck cancer surgery, facial plastic work, and thyroid surgery within our purview of expertise,” she explained. “Once again, I stood up for my specialty, at great risk to my career, to make certain that it was understood—and accepted—that we were the surgical experts in these areas and that they are an integral part of otolaryngology training and credentialing programs.”

■ practice profile

As an AAO-HNS member, Dr. Zajтчuk served on the Government Affairs Committee, the Latin America Committee, and the Subcommittee on Appropriations, and recommends that new or young members join a committee. “Make your mark and volunteer. Look for a mentor, someone whose work you admire. It helps to have a champion to help get you to the right place at the right time. Establish networks and expand your opportunities about what’s possible.”

Looking back on her own career, she remarked, “As Deputy Commander of Walter Reed, I was rated by my abilities to command others, and I am proud to be the first woman in Walter Reed’s history to be selected for this position.”

Dr. Zajтчuk will be featured in the upcoming History of Women in Otolaryngology (WIO) Video Archive Project, a documentary of women in otolaryngology, celebrating the 10th anniversary of the formation of the Academy’s WIO Section. ■



Dr. Joan T. Zajтчuk was awarded the Silver Health Medal by the Minister of Health of the Republic of Vietnam in 1972.



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#IAMOTO

Match Day 2020

Future Faces of Otolaryngology

Match Day 2020 was decidedly different from years past. The COVID-19 pandemic meant social distancing and cancelled receptions at medical schools across the country. Instead of opening an envelope surrounded by their peers, professors, family, and friends, this year's matches opened emails or envelopes at home to find out where they would begin their otolaryngology careers. That didn't stop the excitement, though. New residents shared their accomplishment and joy virtually through online events and social media.

Match Day 2020 brought many new names and faces to the #IAMOTO family. The Academy welcomed new residents on social media and shared with them our Match Day resource page, which has a welcome video and helpful links to articles and learning modules. A very special thank you goes to all the otolaryngology programs and new residents who tagged, tweeted, and posted their Match Day stories.

Visit <http://www.entnet.org/otomatch> to see a compilation of the activity. ■





AAO-HNSF
ANNUAL MEETING
& OTO EXPERIENCE

2020 SEPTEMBER
13-16
BOSTON, MA



Bringing Together the World of Otolaryngology in Boston This Fall

Registration is open for the AAO-HNSF
2020 Annual Meeting & OTO Experience

The AAO-HNSF 2020 Annual Meeting & OTO Experience will unite the specialty as one this September to once again bring together thought leaders, offer unparalleled education, and provide access to the latest products and services to optimize ENT patient care.

As the world continues to adjust to our new reality, living with COVID-19 and its repercussions, everyone in the medical arena has been doing more with less, working in triage mode, and building resilience.

The Annual Meeting Program Committee (AMPC) and the AAO-HNSF leadership at large have focused their efforts on designing a meeting that better prepares attendees to achieve their professional goals and support the specialty.

In its 124th year, the AAO-HNSF 2020 Annual Meeting & OTO Experience will be held September 13-16 in historic Boston, Massachusetts.

Meeting Location

The conference will take place at the Boston Convention & Exhibition Center, 415 Summer Street, Boston, MA 02210. ■

The theme of this year's meeting is "Bringing Together the World of Otolaryngology." As we always have and will continue to do, the community is coming together to help those in need and support one another. Otolaryngologist-head and neck surgeons and medical professionals around the globe are working tirelessly to keep our world safe and healthy. There is no better time than the 2020 Annual Meeting & OTO Experience to recognize the contributions our specialty makes in the name of patient care.

We Are One. This is demonstrated time and again through resiliency, problem-solving, overcoming challenges, and creating opportunities—all in the name of patient care and public health. **We Are One.** This is shown through ongoing support of each other, your peers, the otolaryngology community, and the global house of medicine. The Annual Meeting is an embrace of the year-round collaboration and opportunity to have that peer-to-peer connection firsthand, face-to-face.

Together, we will bring the best and brightest otolaryngologist-head and neck surgeons and all subspecialties from around the globe in one location for cutting-edge education.



AAO-HNSF
ANNUAL MEETING
& OTO EXPERIENCE

2020 SEPTEMBER
13-16
BOSTON, MA

BRINGING TOGETHER *the* WORLD *of* OTOLARYNGOLOGY

#OTOMTG20



The OTO Experience

Engage with the OTO Experience this year in Boston and gain valuable insights from our new education theaters, more hands-on training and learning, and greater opportunities for facilitated networking with your peers.

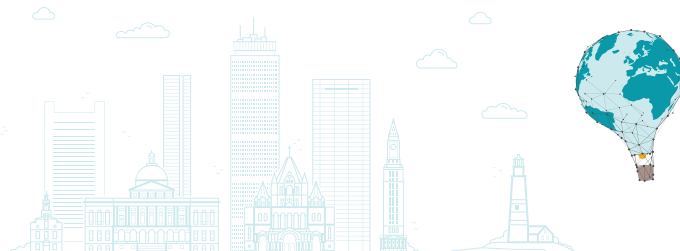
Our COVID-19 experience is teaching us that being on the cutting edge and having access to the latest knowledge in real-time is more important now than ever. Our industry partners have been working together with clinicians to solve the greatest issues being faced during this crisis. Learn what innovations and new processes have come out of this time of discovery and necessary emergency solutions.

The [Re]Connect Lounge will be the central meeting spot for attendees who are looking to network and learn from each other. New technology available for this Annual Meeting will allow you to network and connect with other attendees of interest you identify ahead of the meeting, and the Lounge will be the meeting spot for those exciting face-to-face interactions.

In addition to our Product Theaters that will showcase new products and services available, we will also be hosting the ExcellENT Theater, featuring best-practice tidbits in quickly digestible formats. Stop by to get industry advice on everything from practice management and how to get the most out of telemedicine, to ideas for bringing more procedures into your office setting to maximize efficiency and improve patient outcomes.

Hands-on training is a vital component to your continuing education journey. As new modalities and techniques for delivering procedures and biologics emerge, staying current is more important than ever. Take advantage of several new, easily accessed hands-on labs that will occur on the floor this year from both medical device companies and biotechnology. ■





Program Information

The education program is divided into **11 distinct specialty areas**, allowing you to focus within your specialty or expand your knowledge in other areas.

BMP **Business of Medicine/Practice Management**

CO **Comprehensive Otolaryngology**

ES **Endocrine Surgery**

FPRS **Facial Plastic and Reconstructive Surgery**

HNS **Head and Neck Surgery**

LBE **Laryngology/Broncho-Esophagology**

ON **Otology/Neurotology**

PSQI **Patient Safety and Quality Improvement**

PED **Pediatric Otolaryngology**

RA **Rhinology/Allergy**

SM **Sleep Medicine**

Groundbreaking Education Program Formats

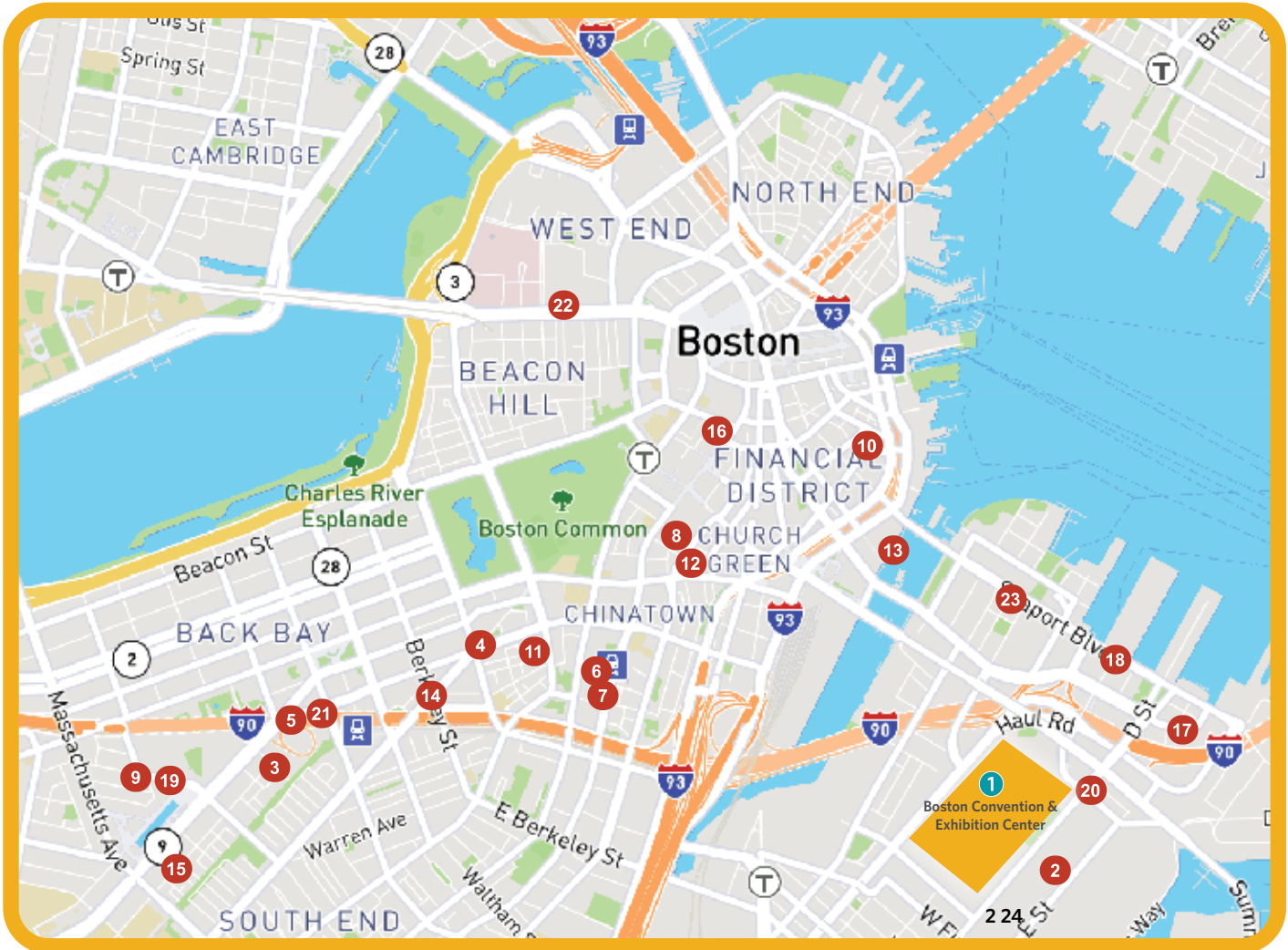
- **Expert Series.** One-hour sessions led by recognized clinicians discussing current diagnostic approaches, therapeutic approaches, and practice management topics.
- **Flash Talks.** TED-style presentations followed by a moderator-driven discussion of case management studies to spark audience participation.
- **International Symposia.** One-hour panel discussions featuring expert international panelists and involving interactive, in-depth state-of-the-art presentations that employ a variety of didactic and interactive education formats.
- **Master of Surgery Video Presentations.** Include six lectures for these short-lecture demonstration videos of key surgical procedures performed by otolaryngologist-head and neck surgeons. Each presentation will conclude with two minutes of audience questions and answers.
- **Meet the Scientific Poster Authors.** Earn CME credit while learning about the latest advancements in research directly from the sources. Ask questions and share experiences with the poster presenters in a truly interactive session. Up to four *AMA PRA Category 1 Credits™* may be earned.
- **Mixed Clinical Presentations.** New for 2020, these presentations will consist of a series of scientific oral presentations and an accompanying expert panel discussion of the topic.
- **Panel Presentations.** These discussion sessions are presented by panelists involving interactive, in-depth state-of-the-art presentations.
- **Rapid Poster Presentations.** These presentations show the highest-ranked poster submissions in each subspecialty, giving the selected poster presenters the opportunity to provide an oral presentation consisting of five slides highlighting and describing the major influence of their research. The presentations will take place during the lunch hour in a designated area near the Poster Pavilion.
- **Scientific Oral Presentations.** These are a series of three- to six-minute presentations focusing on current evidence-based research, surgical procedures, and approaches in clinical sciences and their application to patient care. Each presentation will conclude with two minutes of audience questions and answers.
- **Scientific Posters.** These visual displays detail the latest advancements in otolaryngology research and allow viewers the opportunity to appraise and assimilate scientific evidence for improved patient care practices. Poster authors will be at their boards during specific times on Monday and Tuesday to discuss their findings.
- **Simulation Presentations.** New for 2020, these are one-hour education presentations with simulation tools as the core. Unlike other education adjuncts such as “audience response,” the simulation tools will be integral to the conception and structure of the presentation.
- **Specialty Society Forums.** With Specialty Unity as a focus, each year we will highlight specialty societies’ unique education content. This year, four specialty societies—American Otological Society (AOS), American Rhinologic Society (ARS), American Society of Geriatric Otolaryngology (ASGO), and American Society of Pediatric Otolaryngology (ASPO)—will present tailored content in their dedicated sessions on the Annual Meeting program. ■

Schedule at a Glance

| | September 12 SATURDAY | September 13 SUNDAY | September 14 MONDAY | September 15 TUESDAY | September 16 WEDNESDAY |
|----------|--------------------------|--|--|--|---------------------------|
| 6:00 am | | | | | |
| 7:00 am | | Sunrise Yoga | | | |
| 8:00 am | | Committee Meetings | Education Sessions | Education Sessions | Education Sessions |
| 9:00 am | | Opening Ceremony | Education Sessions | Education Sessions | Education Sessions |
| 10:00 am | | Education Sessions | Neel Lecture Committee Meetings Poster Viewing | Myers Lecture Committee Meetings Poster Viewing | Education Sessions |
| 11:00 am | | Education Sessions | Education Sessions | Education Sessions | Education Sessions |
| 12:00 pm | | Lunch in the OTO Experience | Lunch in the OTO Experience | Lunch in the OTO Experience Academic Bowl | |
| 1:00 pm | | Education Sessions | Education Sessions | Education Sessions | |
| 2:00 pm | | Conley Lecture Committee Meetings | Committee Meetings Poster Viewing | Committee Meetings Poster Viewing | |
| 3:00 pm | | Education Sessions | Education Sessions | Education Sessions | |
| 4:00 pm | | Simulation Showcase and Reception | Simulation Showcase and Reception | Simulation Showcase and Reception | |
| 5:00 pm | | WIO Donor Recognition Reception (by invitation only) | WIO Donor Recognition Reception (by invitation only) | WIO Donor Recognition Reception (by invitation only) | |
| 6:00 pm | | WIO Movie Premiere: History of the Women in Otolaryngology | WIO Movie Premiere: History of the Women in Otolaryngology | WIO Movie Premiere: History of the Women in Otolaryngology | |
| 7:00 pm | | | | | |
| 8:00 pm | | | | | |



Hotel locations



CONVENTION CENTER

1. Boston Convention & Exhibition Center

HOTELS

2. Aloft Boston Seaport District / Element Boston Seaport District
3. Boston Marriott Copley Place
4. Boston Park Plaza
5. Copley Square Hotel
6. Courtyard Boston Downtown

7. Doubletree by Hilton Hotel Boston Downtown
8. Godfrey Hotel Boston
9. Hilton Boston Back Bay
10. Hilton Boston Downtown / Faneuil Hall
11. The Revere Hotel Boston Common
12. Hyatt Regency Boston
13. InterContinental Boston
14. Loews Boston Hotel

15. MidTown Hotel
16. Omni Parker House
17. Renaissance Boston Waterfront Hotel
18. Seaport Hotel
19. Sheraton Boston Hotel
20. The Westin Boston Waterfront Hotel (Headquarter Hotel)
21. Westin Copley Place Boston
22. Wyndham Boston Beacon Hill
23. YOTEL Boston

BRINGING TOGETHER *the* WORLD *of* OTOLARYNGOLOGY

#OTOMTG20

2020 INTERNATIONAL GUESTS OF HONOR: Registrants who reside in Caribbean, Egypt, Germany, and Taiwan will receive a discount of \$100 off their registration fees. *Only one discount per attendee will be honored.*

| MEMBERS CURRENT 2020 <i>(Dues Must be Paid)</i> | EARLY 5/4 - 8/4 | | REGULAR 8/5 - 9/16 | |
|--|--------------------|-------|-----------------------|-------|
| DOMESTIC | FULL | DAILY | FULL | DAILY |
| Resident/In-Training/Medical Student | \$335 | \$155 | \$510 | \$195 |
| Physician/Non-Physician | \$775 | \$390 | \$1,240 | \$495 |
| Advanced Practice Provider | \$440 | \$235 | \$730 | \$300 |
| INTERNATIONAL | | | | |
| Resident/In-Training/Medical Student | \$235 | \$155 | \$410 | \$195 |
| Physician/Non-Physician | \$675 | \$290 | \$1,140 | \$395 |
| Advanced Practice Provider | \$440 | \$135 | \$730 | \$200 |
| INTERNATIONAL LOWER MIDDLE AND LOWER INCOME | | | | |
| Resident/In-Training/Medical Student | \$176 | \$116 | \$308 | \$146 |
| Physician/Non-Physician | \$506 | \$218 | \$855 | \$296 |
| Advanced Practice Provider | \$330 | \$102 | \$547 | \$150 |
| OTHER | | | | |
| Life Member Physician | \$675 | | \$1,140 | |
| Military Physician Member | \$775 | | \$775 | |
| Military Resident/Student Member | \$335 | | \$335 | |
| Retired Physician | \$675 | | \$1,140 | |
| NON-MEMBER | | | | |
| DOMESTIC | | | | |
| Resident/In-Training/Medical Student | \$555 | \$270 | \$875 | \$345 |
| Physician/Non-Physician | \$1,110 | \$575 | \$1,790 | \$720 |
| Advanced Practice Provider | \$555 | \$305 | \$915 | \$375 |
| INTERNATIONAL | | | | |
| Resident/In-Training/Medical Student | \$430 | \$145 | \$735 | \$205 |
| Physician/Non-Physician | \$985 | \$450 | \$1,650 | \$580 |
| Advanced Practice Provider | \$555 | \$305 | \$915 | \$375 |
| INTERNATIONAL LOWER MIDDLE AND LOWER INCOME | | | | |
| Resident/In-Training/Medical Student | \$323 | \$109 | \$551 | \$154 |
| Physician/Non-Physician | \$739 | \$338 | \$1,238 | \$435 |
| Advanced Practice Provider | \$416 | \$229 | \$687 | \$281 |
| OTO EXPERIENCE | | | | |
| Exhibit Hall Only | \$100 per day | | \$150 per day | |
| Exhibitor Full Access | \$865 | | \$1,530 | |
| Exhibit Hall Lunch | | | \$30 per day | |
| OTHER | | | | |
| Sunrise Yoga <i>(Sunday, September 13, 6:30 - 7:00 am)</i> | | | \$25 | |
| Shuttle Bus Pass | | | \$50 | |

Opening Ceremony and Keynote Speaker

8:30 am, Sunday, September 13

Sunday's schedule commingles networking and a dash of fun with the science and education program, kicking off with the Opening Ceremony at 8:30 am. The 2020 Opening Ceremony will bring together leaders in the specialty, a groundbreaking keynote speaker, and eager attendees, setting the tone and pace for the 124th Annual Meeting & OTO Experience.

This year's keynote speaker, Joel Selanikio, MD, is an award-winning physician, TED speaker, futurist, emergency responder, and innovator whose broad career has allowed him to observe and leverage technological changes. A founding member of the World Health Organization's Digital Health Roster of Experts, he is the winner of both the Wall Street Journal Technology Innovation Award for Healthcare and the \$100,000 Lemelson-MIT Award for Sustainable Innovation. Named as one of *Forbes*'s "most powerful innovators," he has been honored as well for his inspirational humanitarian work in responding to disasters and outbreaks, including the 2015 Ebola outbreak in West Africa.

The opening ceremony, where you will also hear from Duane J. Taylor, MD, AAO-HNS/F President, and James C. Denny III, MD, AAO-HNS/F Executive Vice President and CEO, creates the perfect environment for high-profile networking. You won't want to miss the debut of special video presentations that highlight our unique specialty. ■

Full Conference Deals/ Discounts

Deals and Discounts

- Early Bird price – postmarked on or before August 4: member price, \$775; nonmember price, \$1,110
- Regular price – postmarked on or before September 16: member price, \$1,240; nonmember price, \$1,790

Registration Deals

- \$100 discount for International Guests of Honor – Caribbean, Egypt, Germany, and Taiwan
- Military members pay the early rate at all times
- Life and Retired AAO-HNS members receive \$100 discount at all times



AAO-HNSF ANNUAL MEETING & OTO EXPERIENCE 2020 SEPTEMBER 13-16 BOSTON, MA



About Boston



Throughout time, Boston and Massachusetts have played an important part in our country's history. Founded in 1630, just 10 years after the Pilgrims landed at Plymouth, Boston grew as a harbor town and has always been strongly linked to the sea. Boston is unique as it is almost completely surrounded by water, with the Atlantic Ocean on two sides and the Charles River running along the back of the city. Whale watches, harbor cruises, tours of the Boston Tea Party Ship, island hopping, sailing and rowing on the Charles River, touring the U.S.S. Constitution, jogging, cycling, or playing in one of the many parks along the waterways gives visitors plenty to do to discover Boston's nautical history.

Surrounded by natural beauty, Boston's 48 square miles are encircled by a bustling harbor, tranquil coastline, and a strand of green parks designed by Frederick Law Olmsted known as the Emerald Necklace. Two of the parks, the Boston Common and the Public Garden are back-to-back between the Back Bay and downtown neighborhoods in the heart of the city.

Boston is the place to be this September! ■

Registration Information

Visit the Annual Meeting website, www.entannualmeeting.org, and click on the "Registration" button to register online. You will receive your confirmation and periodic updates via email when you register online.

Housing Information

Reserve your hotel room online by August 4. Hotel reservations are available on a first-come, first-served basis. Reserve your room early for the best options. The Boston Marathon is scheduled for Monday, September 14, which coincides with the Annual Meeting. We therefore anticipate hotels will sell out quickly, making it more important than ever to book early within the official hotel block. All hotels require a credit card guarantee.

For more information on registration, hotels, events, activities, and transportation in Boston, visit www.entannualmeeting.org. ■

Continuing Medical Education Credit

The Annual Meeting has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education. AAO-HNSF is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Up to 29 credits will be awarded to physicians when documented by the submission of the 2020 Annual Meeting & OTO Experience evaluation. ■



Preconference Workshops

Back by popular demand are the following preconferences: AAO-HNSF and ACS Thyroid, Parathyroid, and Neck Ultrasound Workshop (Saturday), and Worst Case Scenarios: Managing OTO Emergencies in Practice Workshop (Sunday). Visit our website for prerequisites, details, and pricing. ■

Download the Mobile App

For the latest conference information, visit the Annual Meeting website and download the mobile app. www.entannualmeeting.org.



Special Annual Meeting Offer to Millennium Society Donors

Exclusive access to the Millennium Society Donor Appreciation Lounge

The American Academy of Otolaryngology–Head and Neck Surgery *foundation* is pleased to host the Millennium Society Donor Appreciation Lounge, providing exclusive access for all attending Millennium Society donors. Millennium Society donors are the VIPs of the AAO-HNS *foundation* who have generously donated at least \$1,000 (\$250 for residents or young physicians) to the Annual Fund or \$5,000 to the Hal Foster, MD, Endowment Fund.

The Millennium Society Donor Appreciation Lounge is conveniently located on-site in the convention center, at the

heart of #OTOMTG20. This space provides you with a quiet area to:

- Relax and connect with your colleagues
- Enjoy complimentary breakfast, lunch, and refreshments, Sunday–Wednesday
- Conduct a personal meeting
- Charge your devices, check messages

Join your colleagues today in supporting the specialty by donating at www.entnet.org/donate, and become a Millennium Society donor. To learn about other Millennium Society donor exclusive benefits, go to <http://www.entnet.org/content/millennium-society>. ■



President's Reception

Planned for Sunday night, the President's Reception is your opportunity to reconnect with friends and colleagues. The party will take place at The Lawn on D, located just outside the Boston Convention and Exhibition Center.

Themed "A Taste of Boston," this unique gathering includes live music, an assortment of regional cuisine, and interactive games.

The President's Reception begins at 6:00 pm—be sure to attend! ■





International Guest of Honor 2019: Germany

The German Society of Otorhinolaryngology Head and Neck Surgery—100+ Years of Excellence

“

As President of the AAO-HNS/F, it is my distinct honor and privilege to welcome the German delegation to the AAO-HNSF 2020 Annual Meeting & OTO Experience in Boston, Massachusetts, September 13-16. We look forward to the opportunity for continued friendship, camaraderie, and networking among friends and colleagues at the meeting.

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

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Andreas Dietz, MD, PhD

Andreas Dietz, MD, PhD, President
Hans J. Welkoborsky, MD, DDS, PhD, Secretary

The German Society of Otorhinolaryngology, Head and Neck Surgery (DGHNO-KHC) has its roots going back to 1894. Two German otolaryngology societies existed with the German Otologic Society (Deutsche Otologische Gesellschaft) and the Society of German Laryngologists (Verein Deutscher Laryngologen). With increasing knowledge in the fields, it became evident that one single society would enhance the impact of otolaryngology and probably improve research. Both societies were united in 1921 to the new Society of German Oto-Rhino-Laryngologists, which was renamed to the present name, the German Society of Otorhinolaryngology, Head and Neck Surgery in 1968. Thus, although scientific and clinical otolaryngology has existed in Germany since the 19th century, the actual



Hans J. Welkoborsky, MD, DDS, PhD

society will celebrate its 100th anniversary in 2021.

The society is dedicated to supporting the development of otorhinolaryngology-head and neck surgery in patient care, research, and education, and to improve the excellence in all fields of otorhinolaryngology-head and neck surgery as a united association. The development and evaluation of scientific guidelines for patient care is one of the most important tasks of the society. The society is headed by a board of 11 governors, representing all facets of the field.

Today, the society has more than 5,000 members. They are either employed in one of the 140 ENT departments in teaching hospitals or in one of the 36 university ENT departments. Under the umbrella of the society, 20 self-organized subspecialty working groups were founded—pediatric otolaryngology, head and neck oncology, otology and neuro-otology, plastic and reconstructive surgery, allergy, endoscopy, ultrasound, and sleep medicine. They

each provide specific standards for patient care, scientific development, and clinical practice guidelines and govern the state of the art in their subspecialty.

Another main issue of the society's work is the support of young physicians and young researchers to develop the next generation of otorhinolaryngologists. To support brilliant young researchers and to serve as an incentive for scientific work, the society offers grants and scholarships to deserving fellows, as well as travel grants. The society runs the ENT Academy, which offers academic educational courses during the annual meeting and is decentralized at different places and hospitals.

In 1864 the first scientific journal (*Archiv für Ohrenheilkunde*) was founded. Some years later came the *Archiv für Laryngologie*. Today the society publishes two German language scientific journals that are indexed in PubMed and Medline (*Laryngo-Rhino-Otologie* and *HNO*). Furthermore, the German Society of Otorhinolaryngology, Head and Neck Surgery is closely linked to the Interdisciplinary Working Group of Head and Neck Oncology (IAG-KHT) of the German Cancer Society (DKG), which is embedded into the European Head and Neck Society (EHNS). This highly effective network is mandatory to keep competence in the hands of head and neck surgeons who are mainly based in ENT in Germany. Other strong links exist to the European Laryngeal Society (ELS) and many international societies all over the world.

In the last decades, many international connections and collaborations between the German Society and foreign ENT societies all over the world have been developed and implemented. Many German clinicians and scientists present at the AAO-HNSF Annual Meetings, and many American researchers and clinicians present at the German Annual Meeting, emphasizing the close relationship between the German and American societies. ■

The German Association of Ear-Nose and Throat Surgeons—the Political Think Tank of German ORL

Dirk Heinrich, MD, PhD, President

In 1950, the German ENT surgeons felt the need to organize themselves because a new medical fee schedule was to be implemented on the federal level. Due to its statute, the scientific society of ORL was not allowed to deal with this matter, and in 1951, the German Association of ENT Surgeons (Deutscher Berufsverband der Hals-Nasen-Ohrenärzte e.V.) was founded. In the beginning, the task was to take care of the economic aspects of the profession. But in 1967, the Association held its first convention. The purpose was to provide continuous medical education to all ENT surgeons. The lectures and the practical courses for new methods and skills were greatly accepted.

Today, the convention of the Association also includes the largest industrial exhibition of ENT-related equipment, medication, and machinery in Europe. There are about 6,000 ENT Surgeons in Germany, of which 4,347 work out of their own private practice and 1,467 work in a hospital. In Germany, outpatient care is done by ENT surgeons who have their own private office/practice even though they see mainly patients who are insured by the mandatory sickness funds. Hospital-based doctors deal only with patients who were admitted to the hospital. Over the years, the Association has become the home of about 90 percent of all ENT surgeons with a private practice, but also a good number of hospital-based doctors have joined the Association. Currently, it has about 5,000 members.

The Association is the partner of all major players in the medical field in Germany, including the Chamber of Physicians, the Sickness Funds Doctors Association, the Sickness Funds, the Government, the Minister of Health, and numerous other organizations. It negotiates the medical fee schedule for ORL and all other rules and guidelines in the medical field.

Whenever necessary, these activities are coordinated with our scientific society, the Deutsche Gesellschaft fuer Hals-Nasen-Ohrenheilkunde. The president of the Association is on the Board of Governors of the scientific society, and vice versa. The

Association is organized on the federal level as well as on the state level, because rules in the medical field are often different in the 16 states of the Federal Republic of Germany. The Board of Directors consists of the 16 regional chairs and two representatives from the scientific society. The two organizations also run the German ENT Study Center in order to direct these studies more toward the evidence gaps in ORL.

ORL in Germany faces major challenges. Compared to other countries, the number of hospitalized patients is significantly higher. The government is clearly heading toward more ambulatory care. This will lead to structural changes in ORL. Hospitals will be closed. Surgical procedures will be done in joint ventures of hospitals and private practices. It is the purpose of the Association not only to monitor these upcoming changes, but also to influence them as much as possible—or even invent and manage model ventures to overcome the division of outpatient and hospital-based patient care in Germany. Most medical specialties in Germany have a scientific society but also an association. These associations form a very powerful organization on the federal level, the Spitzenverband Fachaerzte Deutschlands, the top association of all medical specialists, which represents 150,000 physicians. Currently, the president of the ENT Association is also the president of this top association. ■



Dirk Heinrich, MD, PhD



Changing the Dialogue about Aging Voice

VyVy N. Young, MD, and Edie R. Hapner, PhD

Raspy. High-pitched. Low volume. Weak. Tired. Patients have described the progressive changes over time in their voices in myriad ways. Although some may simply assume that these changes are part of the “normal aging” process, about 10 million elderly people do report a voice problem each year. The reported prevalence of dysphonia in the elderly ranges between 6 and 29 percent.

Attributed to the expected changes that occur over time, vocal fold atrophy or presbylaryngus is present in 24-30 percent of elderly dysphonic patients. Presbylaryngus results in loss of vocal fold muscle bulk and/or tone and when combined with aging-related alterations in the respiratory system (e.g., reduced respiratory volume and pressure), results in various manifestations of dysphonia, including raspy vocal quality, difficulty or pain with voice use, increased vocal effort or strain, and decreased vocal loudness or projection.

This clinical presentation has been termed “presbyphonia.” Other symptoms, such as throat tightness/constriction, throat clearing, and even cough, have also been hypothesized to be related to underlying age-related changes to the phonatory and respiratory systems.

Treatment-seeking for presbyphonia, while historically low, has steadily increased over the past 10 years. However, many older adults only seek medical care for reassurance that their voice changes are normal, and that there is no underlying

malignancy. Studies have reported the rate of patients choosing not to treat age-related voice changes ranges between 40 and 80 percent. While it is important to understand a patient's motivation for care, it is equally important to counsel patients that studies have demonstrated that presbyphonia, left untreated, may continue to deteriorate over time.

The otolaryngologist's initial assessment for the presence of presbylaryngus and resulting presbyphonia should include a detailed history-taking and thorough head and neck examination. Visualization of the larynx (i.e., at least laryngoscopy but ideally stroboscopy) is imperative in this population, as presbylaryngus is a diagnosis of exclusion, and other laryngeal disorders including, but not limited to, neuromotor diseases can result in similar patient complaints. Additionally, laryngeal disorders as a result of tobacco use, high vocal demands, or other medical comorbidities can occur simultaneously with changes due to aging and should be considered in treatment decision making. Stroboscopy in particular is vital to look for subtle changes to vocal fold anatomy and vibratory characteristics and degree of glottal closure. It is important to recognize that dysphonia, whether related to aging or another voice disorder, affects patients' quality of life and functionality—occupationally, socially, and emotionally.

Treatment for vocal fold atrophy may include voice therapy, vocal fold augmentation surgery (including thyroplasty), and often a combination of both therapy and medical treatment, with results of treatment being highly variable. While the treatment for presbyphonia can be approached from least invasive to most invasive options, it is critical to recognize that the details from the comprehensive examination, including degree of glottal closure, associated vocal fold vibratory characteristics, respiratory comorbidities, frailty, ability to participate in voice therapy/cognitive status, and impact of the patient's quality of life, and motivation for therapy should all be part of the decision-making about which treatment would best meet the patient's needs.

A recent survey of laryngologists in the United States indicated that voice therapy is the most common first-line treatment for presbyphonia. However, voice therapy, like surgery, encompasses a broad range of options. Decision making in the goals of therapy; the particular methods/treatments used in therapy; the frequency, duration and intensity of voice therapy; and even candidacy for therapy should be based on the results of the speech language pathologist's assessment. In general, voice therapy can be loosely described as targeting three causes of dysphonia:

- recalibration therapies – most often used with people with voice overuse/phonotrauma
- exercise-based exuberant voice therapies – most often used with people with vocal hypophonia/presbyphonia/many neuromotor based disorders
- muscle memory/muscle rebalancing therapies – used in primary muscle tension dysphonia/hyperfunctional underclosure in a normal larynx

Exercise-based exuberant voice therapies have been found to be useful in the behavioral treatment of presbyphonia. Research has shown that exercise-based exuberant voice therapies for presbyphonia, including vocal function exercises, phonation resistance training exercises, expiratory muscle strength training, and Lee Silverman Voice Therapy/LSVT, demonstrate increased vocal loudness, reduced vocal effort, increased vocal endurance, improved cough strength, and, most importantly, increased voice quality of life in presbyphonia.

From a surgical perspective, vocal fold augmentation (both injection and thyroplasty) is hypothesized to counteract the loss of vocal fold muscle bulk or tone and has been shown to be helpful in some patients. This unfortunately is not uniform, and results in the literature remain variable. These studies should be interpreted carefully, however, as they are limited by mixed study populations and small sample sizes. Options for vocal fold augmentation range from temporary (e.g., carboxymethylcellulose or hyaluronic acid) to more lasting materials (e.g., calcium

hydroxyapatite, autologous fat, Silastic or Gore-Tex implants)—all intended to result in vocal fold bulking and medialization. The use of a trial vocal fold injection (VFI) with a temporary material may be helpful to gauge symptom response to augmentation and to guide appropriate expectations prior to consideration of long-term or permanent surgical augmentation procedures. One study has demonstrated that a good response to trial VFI is suggestive of good response to long-term augmentation; however, for those patients who have poor response to trial VFI, their potential for improvement with long-term augmentation remains unclear. Because of the variability of response to augmentation, longer duration materials (e.g., calcium hydroxyapatite) are typically not advocated as first-line treatment for vocal fold atrophy. However, in appropriately selected individuals, long-term augmentation with autologous lipoinjection or thyroplasty can be highly effective in improving patients' symptoms.

Surgical and behavioral treatments offer people with age-related voice changes the opportunity for improved voice quality of life. Recommendations for treatment of symptomatic presbylaryngus are best determined by consideration of a variety of factors: the patient's degree of symptomatology, findings of the laryngeal exam (best with stroboscopy), and the speech-language pathologist's assessment of stimulability and suitability for voice therapy. Most importantly, patients should be counseled that outcomes of treatment will not mimic their "old voice" or "the voice they had when they were much younger" but can provide improved vocal loudness and reduced vocal effort. Patients no longer have to "just live with" these voice challenges. While an individual optimal treatment has not yet been identified, carefully selected interventions do exist that can improve people's ability to communicate effectively at work or volunteer activities, with family and friends, and even on the phone or at the drive-thru. ■

See the online version of this article for a complete list of references used.



Disequilibrium of Aging

Brian J. McKinnon, MD, MBA, MPH

Disequilibrium and associated balance disorders are common in older patients, with a prevalence of about 30 percent in those over the age of 60 years, increasing to 50 percent in those over the age of 85 years. Disequilibrium is considered a significant factor in unintentional falls, with traumatic brain injury (TBI) death a concurrent injury particularly associated with falls in older patients. The Centers of Disease Control and Prevention (CDC) has found that the rate of fall-related TBI deaths in those over the age of 75 years is eight times the rate of those 55-74 years. In the period the CDC reviewed (2008-2017), not only did the national age adjust rate of fall-related TBI deaths increase 17 percent overall, but those over the age of 75 years had the greatest increase in fall-related TBI deaths.

The evaluation of the older patient with disequilibrium is challenging as terms such as “disequilibrium” and “dizziness” may refer to rotary symptoms, as well as anxiety, lightheadedness, and gait disturbances. These multiple concerns may reflect cardiovascular disease, neurological disease, musculoskeletal disease, sensorimotor dysfunction, and/or psychological concerns, not just vestibular dysfunction. Adding the expected concurrent aging-related changes in central integration, vestibular, and proprioceptive functions and sarcopenia, the complexity of assessing and managing the older patient with complaints of dizziness and disequilibrium is daunting.

It is helpful when assessing the older patient with disequilibrium to take an effective, targeted history. One approach

to consider is TiTrATE (timing, triggers, and target examination). Characteristics of the dizziness are clarified when using this method by understanding the timing (onset, duration, evolution), triggers (actions, motions, situations), and duration (chronic vs. acute), allowing for categorization of dizziness as being triggered episodic, spontaneous episodic, post-exposure acute, and spontaneous acute. Associated information on polypharmacy, tinnitus, headache, and hearing loss is useful in understanding the causes of the patient’s dizziness. Complaints of double vision, slurred speech, and difficulty walking may suggest a brainstem or central nervous system cause. In those older patients who have suffered a fall, asking about the circumstances of the fall—the why, what, how, where, and when of the fall—and associated injuries is important because the information is useful not only in understanding the older patient’s complaint of dizziness, but for developing a plan for fall prevention.

Physical examination and focused diagnostic testing clarify the likely cause or causes considered within the differential developed by the older patient’s history. Complaints of episodic symptoms can suggest conditions such as orthostatic hypotension, benign paroxysmal positional vertigo (BPPV), and/or central vertigo, so an exam may include orthostatic testing, Dix-Hallpike maneuver, and neurological exam looking for the four Ds: dysarthria, dysphagia, dysphonia, and dysmetria. For those with more acute symptoms, a physical exam may include a head impulse test, along with evaluation for nystagmus, and skew (vertical deviation with covering and uncovering the eye may suggest a central cause). In older patients with a history

of falls, assessing the condition of the patient’s feet and footwear, lower extremity strength, proprioception, along with formal balance and gait assessment (e.g., timed up and go test, Berg balance scale, and short physical performance battery [SPPB]) may direct diagnosis as well as prevention. Testing of visual acuity, imaging, and hearing testing as clinically indicated should be considered in those without or with history of falls, keeping in mind that some ischemic causes of disequilibrium cannot be excluded by negative MRI imaging.

Disorders such as vestibular neuritis and Ménière’s disease may be effectively managed with judicious prescribing of vestibular suppressants after other diagnoses such as orthostatic hypotension, BPPV, polypharmacy, and central vestibular dysfunction have been addressed or eliminated. Physical therapy is a mainstay for both acute and chronic forms of disequilibrium, as well as for the assessment of fall risk and development of mitigation regimens. The CDC’s Stopping Elderly Accidents, Deaths, & Injuries (STEADI) initiative provides guidance on screening older patients for fall risk, identifying modifiable risk factors and effective interventions.

In closing, otolaryngologists should consider talking to their older patients about the risks of disequilibrium and falls as a routine to help older patients and their families prevent falls and fall-related injuries. When appropriate, suggesting exercises that incorporate balance, strength, and gait activities, (e.g., tai chi) and the removal or elimination of trip hazards takes little time and can go a long way toward making our older patients’ lives safer. ■

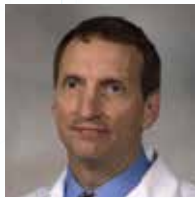
See the online version of this article for a complete list of references used.

Incorporating Advanced Practice Providers into Your Practice

Part III: Recruiting and Contracting



Wendy B. Stern, MD



Scott P. Stringer, MD, MS

Wendy B. Stern, MD

Hopefully you have been following this series, learning more about the physician-advanced practice provider (APP) team approach to healthcare, and are ready to get started with recruiting and contracting. Your practice profile and management will benefit from a variety of approaches, and to help parse out these ideas, I have asked my colleague **Scott P. Stringer, MD, MS**, to share his experience. Dr. Stringer and I have served on several panels together exploring this topic and he offers a wealth of knowledge. He is professor and chair of the Department of Otolaryngology and Communicative Sciences at the University of Mississippi Medical Center.

Scott, thanks for participating. My experience in a private single-specialty group and as an employed physician in a large multispecialty group compliments your academic experiences. One of our favorite recruitment techniques was to offer ENT rotations for physician assistant (PA) and nurse practitioner (NP) students. Of course, we did advertise our positions as well.

What resources do you use to recruit an APP?

We offer rotations as well for APP students,

which serve as an excellent “job interview” for both parties. We give lectures to students at the local PA program. Our existing APPs identify their friends and colleagues as new leads as well. Our university job posting site has drawn several of our recruits. We also list our positions on national job posting services. National NP and PA professional associations, such as American Association of Nurse Practitioners, American Academy of PAs, and Society of Physician Assistants in Otorhinolaryngology / Head & Neck Surgery, have job listing sites in addition to many state organizations.

What information is important to include when recruiting an APP?

The practice expectations, including clinic duties, surgical assisting, call, and consult coverage, are critical to include while recruiting. Any weekend or night duties should be noted. The mechanism for physician backup and support is important to communicate. The APP should know the size of the otolaryngology practice and whether or not other APPs are currently practicing in the group. A salary range and typical benefits may be useful as well.

[Dr. Stern] Over the years I have spoken with many colleagues regarding contracts. It appears that there are an infinite number of approaches. In my private practice, each physician made their own contract with their APP while, as a group, we agreed to supervise the APPs collectively. When we were employed by the large multispecialty group, we added language to our individual contracts that included a supervisory stipend and tied our APPs’ productivity to our own bonus targets so that we could employ the

team approach toward patient care without the pressure of competing for work relative value units (wRVUs).

What are the essentials of a contract?

Beyond the standard human resources essentials in a contract, the salary, incentive structure, benefits, malpractice coverage, and work hour expectations should be included if applicable. Contract termination notice period and conditions for nonrenewal are important elements.

What are some benefits that should be considered, and what about bonuses?

Common benefits include health insurance, malpractice coverage, vacation days consistent with other providers, and continuing education time. Funding for at least some portion of dues, certifications, and continuing education is typically provided. Some employers offer participation in a retirement plan. It is useful to include APPs in any incentive compensation plan commensurate with their contributions to revenue generation.

How is the ramp-up time for training and productivity approached?

The timeline varies based on prior professional and otolaryngology experience. This is highly dependent on the ultimate goal for the APP. For a new graduate, we find that approximately six months is required for an APP to practice in an independent fashion within the practice. An APP with prior otolaryngology experiences can be fully functioning in as little as two to three weeks. ■



Health Disparities in Geriatric Cochlear Implantation

Hearing loss is no longer considered a part of normal aging.

Janet S. Choi, MD, MPH, and Selena E. Briggs, MD, PhD, MBA

Hearing loss is no longer considered a part of normal aging. The negative impact of hearing loss on mental, physical, and cognitive functioning has been well-documented in geriatric populations. Most notably, a recent study suggested hearing

loss as a potentially modifiable risk factor responsible for 9 percent of dementia cases. Although limitations still exist, diverse aural rehabilitation options are now available for older adults depending on the degree and type of their hearing loss. In the past 20 years, cochlear implantation (CI) has been well-established as a safe and effective option for many older adults experiencing moderate to profound hearing loss and not benefiting from conventional amplification.

Previous studies have shown significant improvement in speech perception among older CI recipients comparable to the performance of younger adults. Shorter duration of hearing loss prior to implantation was found to be a robust factor associated with better speech perception, suggesting the importance of earlier recognition of those who meet criteria within geriatric populations. Rates of surgical complications among older adults were equivalent to the rates among younger adults. Quality of life domains including self-esteem, social interaction, and physical activity have improved to even greater extents than in younger CI recipients. Impact of CI on cognitive functioning has not been fully established yet. However, studies with short-term follow-up at 6-12 months have suggested improvement in attention, executive function, and memory postimplantation. There are multiple studies currently ongoing to better understand the long-term impact of CI on cognition in older adults.

The criteria for CI for adults are ever evolving and broadening to encompass a greater degree of residual hearing. Per FDA-labeled indications, non-hybrid CIs are indicated for adults with severe to profound bilateral hearing loss (≥ 70 dB HL) who do not derive benefit from hearing aid use, scoring 40-50 percent or less on sentence recognition testing in the ear to be implanted and scoring 60 percent or less in the best-aided listening condition. Hybrid CIs are indicated for adults with residual low-frequency hearing sensitivity (< 60 dB HL up to and including 500 Hz) and severe to profound high-frequency sensorineural hearing loss (≥ 75 dB HL at 2, 3, and 4 kHz) in the worse hearing ear. There has been a recent expansion of FDA-labeled CI indication to single-sided deafness. Since its earlier approval in Europe in 2013, studies have demonstrated significant benefit in restoration of binaural functionality, improved quality of life, and attenuation of tinnitus after CI among adults with single-sided deafness. In July 2019 the FDA approved the labeling

of MED-EL for use in candidates with asymmetrical hearing loss or single-sided deafness, defined as profound hearing loss and aided word recognition scores of less than 5 percent in the ear to be implanted.

Yet, CI remains underutilized with only 6-10 percent use among adults who may benefit from CI, and these numbers are expected to be even lower among geriatric populations with higher prevalence of moderate-to-severe hearing loss and less surgical care utilization. Unlike hearing aids, CI is covered by most healthcare plans. Private insurance, Medicare, and Medicaid cover non-hybrid CIs for those who meet the FDA indications. Hybrid CIs are also covered by most insurance plans and typically Medicaid. Coverage of CI for single-sided deafness currently varies by insurance plan, and some require patients to first try other technologies, including a hearing aid or a CROS system. Most insurance plans cover CI devices and related professional services, but it is important to note that there are multiple post-op visits and long-term aural rehabilitation requiring additional financial and social support for CI's full benefit.

Interestingly, studies have observed significant sociodemographic disparities in CI by age, race, income, and rural/urban environment. A retrospective study examining adult CI recipients (mean age 61-62 years) in rural and urban settings in the United States demonstrated that the rural participants had a greater time interval from the onset of hearing loss to the time of CI at 36 years compared with urban-metro participants at 29 years. The rural participants reported a significantly longer commute to the CI center, lower average income, and lower percentage with private insurance coverage. This represents an opportunity for which telehealth may make a positive significant impact in the care of CI patients, compliance, and outcomes. Another retrospective study of adult CI recipients (mean age 61) demonstrated that nonwhite race and increased age were associated with increased time to

CI. Nonwhite CI recipients were six times less likely to receive CI during each year of hearing loss as compared with white CI recipients. In addition to longer time to CI, poorer scores in post-CI quality of life measures were associated with lower socioeconomic status. A multicenter cross-sectional study of adult CI recipients (mean age 60) reported that having lower household income was associated with lower CI-specific quality of life scores in communication, environment, and social domains.

The safety and efficacy of CI have been well-established among older adults who meet the criteria and have access to a CI center. CI technology has been continually evolving to provide FDA-approved CI devices for older adults with various degrees of hearing loss. Both private insurance and Medicare/Medicaid provide a robust reimbursement policy across the nation. Still, the literature suggests that a majority of older CI candidates do not receive CI and that there is a significant delay to referral and implantation even among the few who receive CI. While there is a need for continuing research to better improve our current CI technology and understand the long-term outcomes, it is also time to consider those older CI candidates in the community suffering from hearing loss. There are multiple support programs and policies established to promote hearing care that focus on CI in the pediatric population. There is an opportunity for increased support programming and policy focusing on the adult—and geriatric, specifically—population. Future studies are needed to better understand risk factors associated with delay in referral for CI in older adults outside clinic and ways to improve access to CI among minority, low-income, and rural populations. There should be greater organizational effort partnering with our primary care colleagues to promote awareness among geriatric populations that hearing loss does not have to be part of their aging process. ■

See the online version of this article for a complete list of references used.

Upper Airway Stimulation: A New Frontier in the Treatment of OSA

Jeffrey J. Stanley, MD, for the General Otolaryngology and Sleep Education Committee

Obstructive sleep apnea (OSA) affects a significant portion of the adult population. Many patients do not tolerate continuous positive airway pressure (CPAP), which is the gold-standard treatment.

Over the past 30 years, numerous surgeries have been developed to enlarge the upper airway but fail to address the underlying loss of muscle tone associated with sleep onset, which is pivotal to the pathogenesis of obstructive sleep apnea.

In contrast, upper airway stimulation (UAS), also known as hypoglossal nerve stimulation, is designed to increase upper airway muscle tone, thereby alleviating obstructive events. Stimulation of the hypoglossal nerve activates the principal upper airway dilator, the genioglossus muscle. Importantly, due to mechanical coupling of the palatoglossus muscle that insinuates itself into the intrinsic tongue musculature, there is an increase in the retropalatal airway with each anterior tongue movement. Therefore, UAS leads to an increase in both the retroglottal and retropalatal airway during sleep.

In 2014 the first upper air stimulation device, produced by Inspire Medical Systems, Inc., was approved by the Food and Drug Administration. In 2016 the American Academy of Otolaryngology–Head and Neck Surgery released a support statement for this mode of therapy. Indications for UAS include CPAP intolerance at age 22 years or older, body mass index (BMI) <35, apnea hypopnea index (AHI) 15–65, and absence of complete concentric collapse of the velopharynx during drug-induced sleep endoscopy.

The hypoglossal nerve stimulator consists of three components: (1) the nerve stimulator, (2) the neurogenerator, and (3) the respiratory sensor (Figure 1). During sleep, the respiratory sensor detects a change in intrathoracic pressure with inspiration leading to stimulation of the hypoglossal nerve via the neurogenerator

and nerve stimulator electrode. This leads to a stiffening of the tongue as well as anterior displacement of both the tongue and soft palate.

A five-year follow-up study on patients enrolled in the initial Stimulation Therapy for Apnea Reduction (STAR) trial was published in 2018. The median AHI decreased from 32 to 14 at five years with good durability of effect. The response rate, defined as at least a 50 percent decrease in AHI and a postoperative AHI < 20 was 75 percent, and 44 percent had resolution of their sleep apnea with an AHI < 5. In addition, quality of life measures were significantly improved at one and five years following implantation. Nightly use was 86 percent and 80 percent at one and five years, respectively.

The ADHERE registry represents a collection of retrospective and prospective outcome measures across multiple institutions in the United States and Europe and is currently the largest cohort of patients using UAS to date. In 2008 the ADHERE registry reported strikingly similar results to those of the STAR study patients, reported above. Additional studies published from the registry this past year examined the potential effect of previous surgery as well as age on UAS outcomes.

Serious complications related to UAS are rare, although tongue abrasion and discomfort with stimulation requiring adjustment in settings or use of a dental guard have been reported in up to 20 percent of patients. Postoperative morbidity is low with an immediate return to a normal diet and typically only mild to moderate incisional pain.

The future of UAS includes the potential expansion of current surgical indications and identification of patient factors that may affect surgical outcomes. With the known association between OSA, congestive heart failure, and arrhythmias, there is an increased likelihood of these patients needing an implantable cardiac device. Due to the proximity in the upper chest, interaction between these two devices is theoretically possible. Only a small case series of patients with both a cardiac implant and an UAS implant have been reported with

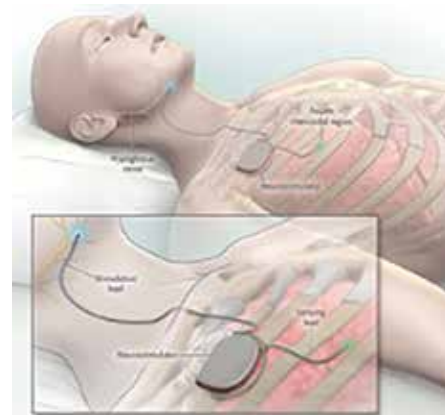


Figure 1. Hypoglossal nerve stimulator. © Inspire Medical Systems, Inc. Image used by permission.

no device-to-device interactions observed, but further research is needed to address potential safety concerns. Finally, current indications for UAS include adult-aged patients only. A recent study on nonobese patients with Down syndrome, ages 10–21 years, reported promising results for this patient population, who often have a combination of generalized hypotonia and structural abnormalities accounting for their high prevalence of OSA and high-failure rate following adenotonsillectomy.

In summary, the overall efficacy of UAS is high, with approximately 70 percent responding to therapy, and surgical morbidity is low in comparison to traditional structural surgery for OSA. There is growing enthusiasm for this surgical procedure, since for the first time in many years we are now seeing high numbers of patients (> 40 percent) with resolution of their OSA with UAS therapy. As with any relatively new procedure, many questions remain, including ideal patient selection, long-term compliance rates, durability of results, the effect of fluctuations in BMI, the effect of prior or additional structural surgeries and the long-term effect on cardiovascular morbidity and mortality associated with OSA. Research on all these topics is underway as UAS appears to be a new frontier in the surgical treatment of OSA. ■

See the online version of this article for a complete list of references used.

Transition to In-office Treatments: Sleep

Ofer Jacobowitz, MD, PhD

Otolaryngologists are fast recognized by the public, government, and industry as leaders in the management of obstructive sleep apnea (OSA). With a prevalence that is estimated to approach 14 percent of the population, OSA is not simple to treat, and patients benefit from a personalized approach. Otolaryngologists can prescribe and facilitate treatment of positive airway pressure (PAP) devices, fit oral appliances, and perform procedures to treat the nasal airway and the soft palate, all in the office/clinic setting.

The Nose, Up-front

The nasal airway is fundamental for PAP treatment success and for sleep quality even in absence of OSA, and otolaryngologists are the experts who critically assess and treat the nasal airway, medically and surgically. Both nasal obstruction and use of “full face,” oronasal interfaces may result in higher pressures, leaks, discomfort, and treatment failure.

There has been a major transition in nasal procedures from the OR to the clinic setting. While inferior turbinate injection with steroids and radiofrequency-mediated thermal reduction have been performed under local anesthesia for decades, the menu has grown. With greater comfort in the application of local anesthesia and new or improved devices, microdebrider-assisted turbinate and swell body reduction and nasal polypectomy may be safely performed in the office. Simply apply lidocaine- or tetracaine-soaked pledgets for 15-20 minutes, allowing for painless anesthetic injections and consequently, well-tolerated procedures, in my experience.

Nasal valve obstruction can now be treated in the office in selected patients who respond to a modified Cottle maneuver. The Latara implants can be delivered using a hollow canula device under local anesthesia of the nasal rim and lateral nose to treat nasal valve obstruction. With the Vivaer device, temperature-controlled radiofrequency is applied with pressure to modify the lateral nasal wall/valve using only

intranasal local anesthesia. Both treatments are rapid, easily performed, and have shown improvement in nasal obstruction scores to a similar extent obtained by major surgery in selected patients.

Even septoplasty is an in-office option in selected patients, performed under local anesthesia or with minimal sedation. To reduce invasiveness, one may use septal burs, and more limited flap elevations. Traditional septal modification with standard instruments is also possible, in selected patients, per surgeon’s comfort. More recently, I have been performing balloon-assisted septoplasty, using the Relieva TRACT nasal dilation system, which allows for septal mobilization and easier dissection and removal of septal spurs. Many options are thus available at reduced cost to patients and greater efficiency for the otolaryngologists.

Oral Appliances, in Your Hands

Oral Appliance Therapy (OAT) is a proven treatment for snoring and OSA, usually preferred over PAP by patients. OAT is not a “dental treatment” but a medical treatment for a medical disorder, performed by otolaryngologists or qualified dentists, as supported by a position statement of the AAO-HNSF. Appliances may be used for primary treatment of OSA, after upper airway surgery, or with positional treatment or PAP.

Since appliances are anchored by the dentition and gingiva, dental optimization by a dentist is a prerequisite. Treatment risks include occlusal changes, discomfort, partial efficacy, or failure, and these must be accepted by the patient. Thermoplastic, or “boil and bite,” appliances, are inexpensive and immediately available, although not as durable as custom, lab-made appliances and not covered by some carriers. They can often be used as an adjunct to PAP (e.g., for travel). Custom appliances are preferred but require hands-on training for production and fitting and manufacturing by a dental lab at a cost. Introductory courses for OAT are available at the AAO-HNSF Annual Meeting.

OAT is usually covered by commercial insurance carriers, but policy review and

precertification or predetermination are advised for those beginning to implement OAT. Some carriers require a prior 45-day trial of PAP therapy. CMS carriers exclude medical doctors from fitting oral appliances, although the rationale is not evidence based. The great benefit to patients with OAT by otolaryngologists is access and affordability, as dentists rarely accept insurance payments in full and patients may be left untreated.

The Palatal Menu

Snoring is a very important issue for patients and their families. Snoring is difficult to treat and usually responds to some combination of lifestyle modification (alcohol and smoking reduction), non-supine positioning, weight loss, nasal optimization, OAT, and palatal modification in the office. Many patients prefer an office palatal procedure to an ongoing treatment but should be advised that effect may be partial and not permanent.

To reduce palatal vibrations, options include stiffening, shortening, and suspension. Gargling with liquid topical anesthetic repeatedly facilitates injection of local anesthetics for palatal modification. Premedication with Tylenol or NSAIDS is beneficial. The uvula should not be removed but may be shortened. The palate may be easily stiffened by chemical injection, thermal ablation (i.e., radiofrequency), or insertion of implants. The Pillar implants are no longer available, but Elevo implants are a newer option. Concurrently, I often shorten the palate using scissor and forceps, targeting the lateral webbing of the posterior pillar. For some, I use barbed sutures to suspend and stiffen the palate. For post-op management, NSAIDS, “magic” mouthwash, and Carafate may be used, as appropriate.

Many options and many treatments are in our hands. Our patients benefit from personalized care in a single location by the experts of the upper airway.

By the way, for sleep in the office, it would be great for us all to get sleep pods where we can take a power nap. ■

Author disclosure: Consultant for Aerin Medical, whose Vivaer device is used for nasal airway modification

Emerging Data Support for Elderly Patients with

Nicole C. Schmitt, MD, and Sidharth V. Puram, MD, PhD

Head and neck surgeons are increasingly concerned about following best practices when caring for elderly individuals with head and neck cancer. At the AAO-HNSF 2019 Annual Meeting & OTO Experience, this topic organically arose during three separate oncologic committee meetings. As life expectancy and the median age of the population continue to rise, otolaryngologists will increasingly encounter geriatric head and neck cancer patients. Surgeons and oncologists may be reluctant to offer curative therapy to these patients based on concerns about increased morbidity and mortality versus younger cancer patients. However, multiple studies demonstrate improved outcomes and reduced cost when elderly head and neck cancer patients are treated according to National Comprehensive Cancer Network (NCCN) Guidelines. Ironically, the clinical trials on which the NCCN Guidelines are based have included very few geriatric patients. Thus, treatment recommendations must often be modified to accommodate

elderly patients and their unique medical and personal considerations.

While it may coincide with advanced chronological age and comorbidities, frailty is a distinct condition consisting of physiologic decline and medical vulnerability. Frailty—more so than age, performance status, and comorbidity indices—has been linked to poor health outcomes and mortality in cancer patients. A comprehensive geriatric assessment (CGA) has been recommended for identification of frail patients who are most in need of treatment modifications, but geriatric assessment scales have not yet been widely used in clinical oncology practices.

Among the geriatric population, distinct challenges arise when considering options for surgical management of oncologic diagnoses. On the most basic level, elderly individuals have physiologic changes in their connective tissue, with loss or replacement of elastin and collagen, which likely impairs healing. These features place patients at greater risk for complications such as wound breakdown, fistula, or dehiscence. Among these individuals, the vigor of immune response may also be blunted, adding further susceptibility to surgical site infection and its complications. Because the

geriatric cohort will generally have more medical comorbidities than other groups, they will also be less likely to cope with such complications while being at greater risk for perioperative mortality and medical complications (e.g., respiratory failure). This higher risk of complications should be carefully explained when counseling patients on surgery, with the important caveat that elderly patients in good health and favorable performance status (i.e., fit) can have optimal oncologic outcomes. Certainly, involvement of the geriatric consult service as well as the patient's primary physician represents a best practice that facilitates a tailored, individualized approach.

When considering oncologic ablation in the geriatric population, curative intent surgery demands a nearly identical procedure to younger individuals; however, reconstruction can be more nuanced. Indeed, a study of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) dataset explored free and regional pedicled flap reconstruction in patients with varying degrees of frailty. Modified frailty index was predictive of Clavin-Dindo classification IV complications, specifically in free flaps but not regional flaps. Similarly, retrospective



a Personalized Approach Head and Neck Cancer

studies have suggested that free flaps in octogenarians may result in longer ICU stays and complications, although flap failure and overall length of stay may be similar. Importantly, the 30-day mortality rate was significantly higher in the octogenarian cohort; however, this study did not adjust for comorbidities or pathology. Nevertheless, regional flaps such as the supraclavicular island, pectoralis major, and submental flap should at least be considered in the geriatric population. With that said, free flaps can be utilized with careful patient selection: When these procedures are successfully completed in the elderly, quality of life measures appear to be similarly rated, higher-quality care may reduce costs, donor site morbidity may be comparable to younger patients, and functional outcomes such as swallow may be achievable. Thus, all rungs of the reconstructive ladder should be thoughtfully considered to determine what options may be best for a given patient. Indeed, a rigid refusal to consider surgery, or reconstruction for that matter, in elderly individuals purely based on age appears to be comprehensively rejected by these prior studies.

For geriatric patients whose treatment plan includes primary or adjuvant radiation or chemoradiation, additional challenges

are encountered. Patients with limited mobility must often rely on younger family members to transport them to radiation appointments over several weeks, which can become a logistic hardship for the entire family. Elderly patients are also particularly susceptible to adverse effects of chemotherapy and radiation. Swallowing may already be impaired by the aging process, and elderly patients are less able to tolerate aspiration. Many patients with advanced-age renal insufficiency or hearing loss may be offered radiation alone or with cetuximab, with the possibility of decreased efficacy versus platinum-based regimens. Of further concern, adding chemotherapy to radiation, or adding any adjuvant therapy after surgery, may have a less-pronounced or negligible survival benefit in elderly patients. Despite these limitations, multiple studies have demonstrated the feasibility of curative intent radiation or chemoradiation in elderly patients who are not frail, with favorable rates of locoregional control. Elderly patients should be counseled to expect higher rates of toxicity and, often, the need for a gastrostomy feeding tube.

Immunotherapy in the form of anti-PD-1 immune checkpoint blockade (ICB) has been FDA-approved for recurrent or metastatic

head and neck cancer since 2016. Unlike systemic chemotherapy, anti-PD-1 ICB is usually well tolerated, even by elderly patients, with nearly half of treated patients demonstrating long-lasting responses or periods of stable disease.

Patients with advanced age or medical frailty with limited life expectancy may opt to forgo curative intent treatment in favor of palliative care upon diagnosis. When instituted early in appropriate patients, supportive care may lead to improved survival in addition to enhanced quality of life.

In conclusion, treatment of elderly patients with head and neck cancer requires a personalized approach. Medical comorbidities, frailty, life expectancy, quality of life, and support systems should be considered for each individual patient. When feasible, geriatric physicians should be integrated into multidisciplinary head and neck cancer teams, and clinical trials should be designed specifically for elderly patients. Moving forward, increasing data on outcomes of geriatric head and neck cancer patients will enhance our confidence in counseling these patients to empower them to make personalized treatment decisions. ■

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