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

NOVEMBER 2020

International Regional Roundtables

Bringing Together the World of Otolaryngology Virtually

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Why Going Global Is More Important Than Ever

I had the great honor and privilege to serve on the Global Panel Presentation at the International Advisory Board (IAB) General Assembly held during the AAO-HNSF 2020 Virtual Annual Meeting. The panel was moderated by IAB Chair, **Sady Selaimen da Costa, MD, MSc, PhD,** (Brazil) and Chair-elect, **Karl Hoermann, MD** (Germany). I was joined on this esteemed panel by Dong-Young Kim, MD (Korea), **Cem Meco, MD, FEBORL-HNS** (Turkey), **Titus S. Ibekwe, MBBS, FWACS,** (Nigeria), **Hector De la Garza, MD,** (Mexico), and **Thana Hikmet Nassir, MD, PhD, FICMS,** (Iraq). The topic was "Otorhinolaryngology in the COVID-19 Era: The Global Experience." The panelists described the impact of the pandemic upon education and training. While the COVID-19 pandemic has impacted our global community with loss of life, human suffering, and adverse economic consequences, the pandemic has also created tremendous innovation in care paradigms and education platforms. In many respects, the pandemic has brought us closer together. Virtual platforms have allowed greater participation of members across the globe. There has been tremendous innovation in online learning platforms and virtual meetings. The new FLEX multimedia education platform is very timely.

Launched in September 2020 and already with more than 3,000 subscribers as of October 20, FLEX delivers knowledge, education, clinical tools, and professional support to the otolaryngology community in a way that can be applied directly to practice and patient care. The vision for FLEX came via the work of the AAO-HNSF Future of Education Task Force, and today more than 130 experts in the specialty contributed and continue to contribute to the content that is delivered to subscribers using innovative and cutting-edge education technology. For more information about FLEX, go to www.entnet.org/flex.

I had the privilege of serving on the International Task Force, appointed by **Gayle E. Woodson, MD,** Past President of the AAO-HNS/F several years ago. The task force was charged with how to foster and embrace the global otolaryngology community to a greater extent. The creation of our IAB was an outcome of the recommendations of this task force. I would say that the creation of the IAB has far exceeded our collective expectations. Our partnership with the global otolaryngology community has never been stronger. We are privileged to have the opportunity to share best practices, to learn from one another, and to foster even more productive collaborations. We are indebted to the inaugural IAB Chair, **Johannes Jacobus Fagan, MBChB, FCS(SA).** Clearly, we face unprecedented disruptions in care, education, and research, yet we need to leverage bold and innovative strategies to allow us to successfully navigate our collective future together. This reminds me of a favorite African proverb, *"If you want to go fast, go alone, if you want to go far, go together."*

Based on the valuable input from our international colleagues as delivered through many joint meetings, roundtable discussions, the International Corresponding Societies, and the IAB leadership, the Academy has taken multiple steps to facilitate more widespread international engagement through special pricing models for membership and education products. We are pleased to announce that we are partnering with EvermedTV to help distribute Annual Meeting content and other selected education materials to the global community. I know that we can go far as a global otolaryngology community. Together, we can realize our collective vision and mission. ■

Carol R. Bradford, MD, MS
AAO-HNS/F President

"The pandemic has also created tremendous innovation in care paradigms and education platforms. In many respects, the pandemic has brought us closer together. Virtual platforms have allowed greater participation of members across the globe."

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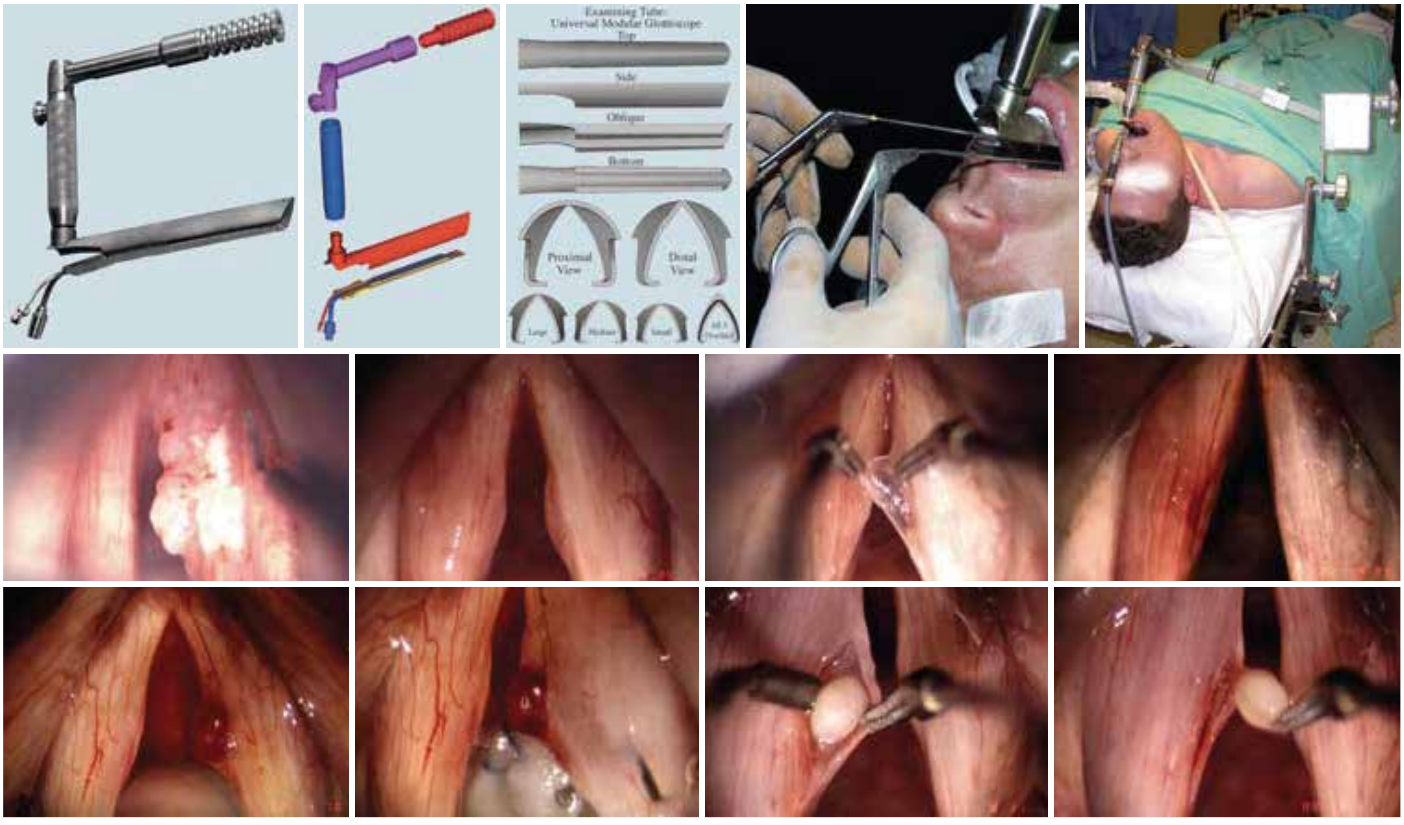

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Real-World Impacts on Otolaryngology Practice Models: Pitfalls to Consider

As we approach the end of one of the most disruptive and tumultuous years of the last century, hoping to regain some degree of equilibrium, it is important to recognize and analyze not only the major, well-known consequences of COVID-19, social unrest, natural disasters, and divisive politics, but also some of the under-recognized impacts on our medical providers.

Primary care and specialty physicians alike worldwide have experienced significant disruption in their practices, particularly during the early months of the pandemic. Whether in private practice or in an employed model, ALL physicians suffered from a marked reduction in patient encounters and a resultant significant decline in RVU production and revenue generation. Physicians in all practice situations experienced similar, yet unique, consequences.

I have researched and written or spoken about academic, employed, and private practice situations on a number of occasions, detailing theoretical advantages, disadvantages, and pitfalls of each model. Theoretically, discussions can be sterile, especially since most job seekers tend to choose a position based on characteristics of particular importance to their personal situation, generally favoring the positive aspects of the job while minimizing the more unfavorable possibilities. The widespread economic hardships faced by our members regardless of practice type or geographic location have laid bare the "dark side" of many employment arrangements, exposing some of the detrimental aspects enforceable by employers.

When selling a practice to or joining a nonphysician entity, such as a hospital system, despite how attractive the offer may be and how favorable the initial terms appear and what a great relationship you may have with the current leadership of the acquiring institution, the original deal that you make will likely be the best you ever see. This scenario has played out repeatedly for primary care and specialty practices across the board. Frequently "second contracts" raise RVU production requirements and alter job-related descriptions, and unfortunately many expand the already existing restrictive covenant, further limiting local options. These realities occur during "normal" practice and economic circumstances, "the best of times," and much has been written designed to prepare and inform prospective physicians about the benefits and pitfalls to be aware of. One aspect that is not typically addressed widely in the hospital system acquisition model, but has been highlighted in the venture capital model, is the potential and likelihood that the original purchasing entity could itself be purchased by a larger or competing system. Events such as these have the potential to disrupt any prior positive relationships with system leadership and subsequently alter the goals and mission of the organization, resulting in change in employed physician practices.

The last nine months have certainly not represented "the best of times" and the revenue cycle on both the income and expense sides has been dramatically affected despite meaningful governmental subsidy in the United States. Globally, most countries have not had the benefit of additional government support. The current situation has spawned some creative interpretations of existing agreements that have not been favorable to employed physicians. I have spoken to more members about their situations in the last six months than I have in the previous five years. Some of their experiences are eye-opening and worrisome as a higher percentage of physicians become employed, particularly if the employed model persists as is or escalates after the end of the public health emergency.

The following compilation of personally-related experiences have been de-identified and not every situation has been experienced by all interviewees. Early on during the pandemic, physicians were expected, and in some circumstances ordered, to provide care with inadequate protective health equipment (PHE), to practice in areas outside their primary training and practice situation, to accept salary reductions and suspension of benefits, such as education funding and PTO. As practice has resumed, many are getting pressured to generate more revenues by increasing procedures, performing services at a more expensive "site of service," working more hours, foregoing benefits, and upcoding visits. At some locations, those who complain or do not conform are disciplined or dismissed. I am aware of several instances where physicians were asked to return salary because they did not generate the expected RVUs when facilities were closed, even when they were unable to see patients. It is also important to be aware that these consequences are not limited to individual physicians but apply to entire groups or portions of groups that are seen as noncompliant.

In the upcoming year, President-elect **Ken Yanagisawa, MD,** and I will be presenting a series of articles in the *Bulletin* highlighting the real-world experiences of physicians in the various otolaryngology practice models. ■

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

> I have spoken to more members about their situations in the last six months than I have in the previous five years. Some of their experiences are eye-opening and worrisome as a higher percentage of physicians become employed, particularly if the employed model persists as is or escalates after the end of the public health emergency.

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AAO-HNS CELEBRATING 125 YEARS 1896 - 2021

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125 STRONG CAMPAIGN

AAO-HNS/F Celebrates 125 Years

This year the AAO-HNS/F is celebrating our 125th anniversary as a specialty organization. We are planning a number of events to commemorate our history that will culminate at our AAO-HNSF 2021 Annual Meeting & OTO Experience in Los Angeles, California, October 3-6, 2021. Our President, **Carol R. Bradford, MD, MS,** is pleased to announce our "Shaping Our Future Together: 125 Strong Campaign" that will raise funds for key initiatives in four different areas that will complement our existing strategic programs. Under the leadership of Dr. Bradford, our Board of Directors has selected the following four general areas for which specific projects and programs will be identified and developed: (1) Diversity, Equity, and Inclusion; (2) Education; (3) Leadership Development and Mentorship; and (4) Wellness. Dr. Bradford feels "these endeavors will resonate with and capture distinct passions that interest our members." The selected proposals will be additions or enhancements to current activities that otherwise would go unfunded for lack of resources.

Dr. Bradford has chosen two Past Presidents, **Sujana S. Chandrasekhar, MD,** and **Albert L. Merati, MD,** to Co-chair this exciting campaign. **Angela M. Powell, MD,** will lead the Diversity, Equity, and Inclusion team; **Richard V. Smith, MD**, will lead the Education team; **Kathleen L. Yaremchuk, MD, MSA,** will lead the Leadership Development and Mentorship team; and **Dana M. Thompson, MD, MS,** will lead the Wellness team. Donors will be able to select the specific areas of interest and projects they wish to contribute, and all monies received will be spent on the designated areas over the next several years.


Sujana S. Chandrasekhar, MD

Dr. Chandrasekhar reflects, "The Academy has been my cherished second family since I began my residency. I still remember the wonder I felt at my first Annual Meeting, learning all I could from the courses there and back home, working on committees and sections, and taking Academy-sponsored leadership and business courses. I cherish the friendships I've made here. I am honored to give back so that others can benefit. I hope you can join us for the 125th Campaign."


Albert L. Merati, MD

Dr. Merati observes, "There is a powerful blend of content and community that drives our AAO-HNS membership—this has never been more apparent than in the past year. Our members have strong feelings and hopes about our field and our future together; the AAO-HNS 125th campaign offers direct, immediate ways to act and help shape our next decade together."

Look for the full details as we kick off the campaign in our commemorative 125th Anniversary *Bulletin* issue in January 2021. At that time, there will be complete descriptions of the selected programs within each area of focus along with how we can all join together to make this campaign a success. ■

at the forefront

Information, resources, and updates in this section

WIO Celebrates 10 Years in Virtual Style

Education Opportunities in Pediatric Otolaryngology

ENTHealth Information for Your Patients

Humanitarian Travel Grant: Medical Mission in Kenya

READ MORE ONLINE

Humanitarian Travel Grant: Medical Mission in Kenya

WIO WOMEN IN OTOLARYNGOLOGY

WIO Celebrates 10 Years in Virtual Style

The 10th anniversary celebration of the establishment of the Section for Women in Otolaryngology (WIO) and the WIO Endowment (WIOE) was held on October 3, during the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience. The culmination of a year's work of dedicated volunteers and leaders, the festivities included a virtual watch party for the premiere of the WIO documentary, "Four Days in Boston: A History of the AAO-HNS Section for Women in Otolaryngology (WIO)." Don't worry if you missed it; you can access the video and find out how you can get involved in supporting the goals and initiatives of WIO and the WIOE at www.entnet.org/wio. ■

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HUMANITARIAN TRAVEL GRANT

Medical Mission in Kenya

Nicholas Mildenhall, MD, had the opportunity to work at the AIC Kijabe Hospital in rural Kenya under the practice of **David D. Nolen, MD,** an alumnus of the same residency program.

Dr. Mildenhall worked alongside both mission and healthcare providers, including a Kenyan otolaryngology resident and a Liberian general surgery resident. An appreciation of cultural differences developed through a shared goal to help patients. Each day Dr. Mildenhall and his colleagues served busy clinics and operating rooms, managing a broad spectrum of diseases. The patients often traveled from significant distances and at great cost to receive specialty care.

Dr. Mildenhall noted the valuable experience in working with others who were from around the globe. "We were able to better appreciate our cultural differences through our joint desire to help patients, which was an enriching experience."

Dr. Mildenhall treated common illnesses and a variety of diseases in an area prevalent with HIV and Epstein-Barr virus infections. While he had the privilege of treating both children and adults, he and his team often faced difficult choices in a setting with limited resources and access to care. An inability to get all the tests needed and lack of instruments often required Dr. Mildenhall to assess what the most valuable care would be and develop a new

aspect of creativity and flexibility in surgery.

"It was humbling to have the opportunity to help treat such a grateful population with little material wealth. I learned so much from them beyond medical knowledge, and I look forward to applying those new lessons to my personal life and practice of medicine," said Dr. Mildenhall. ■

READ MORE ONLINE
Longer article available

SRF SECTION FOR RESIDENTS AND FELLOWS-IN-TRAINING

COVID-19 and Racial Disparities: An Update

Factors Contributing to Disparities

Zainab Farzal, MD, MPH, SRF Chair, and
Kevin J. Contrera, MD, MPH, SRF BOG Governor

Early in the pandemic, the widespread, disproportionate impact of COVID-19 was evident among minorities, particularly Hispanic, Black, and Native American communities in the United States. This has been repeatedly demonstrated through different types of analyses, including evaluations of relative cases, hospitalizations, and deaths. For instance, the Centers for Disease Control and Prevention (CDC) reported that non-Hispanic Black, Hispanic or Latino, and non-Hispanic American Indian or Alaska Native persons were hospitalized at rates approximately five times that of non-Hispanic White persons.[1] The data primarily focused on adult patients particularly since pediatric cases were initially rare. A pediatric study published in *The New England Journal of Medicine* in late July 2020 demonstrated a similar disparate incidence of a condition known as multisystem inflammatory syndrome in children (MIS-C). A diagnosis of MIS-C was made if certain criteria were met, including age under 21 years, fever >38°C lasting over 24 hours, multisystem (two or more) organ involvement, increase in inflammatory markers, and lab confirmation of SARS-CoV-2 infection. Conducted across 53 academic centers around the country, 61% of the patients were either Black or Hispanic non-White.[2] Nearly all patients (73%) were previously healthy, but 71% also involved four or more organ systems.[2]

The data from the pediatric study highlight the intertwinement of comorbidities, systemic racism, and public health in the United States. Certain underlying conditions such as diabetes and cardiovascular disease put individuals at risk for COVID-19 and are disproportionately more common among people of color. However, the unequal incidence of COVID-19 among otherwise healthy children of color best highlights other, more deep-rooted, systemic risk factors. These include discrimination in testing, insurance status, or medical utilization. Additionally, many risks faced by people of color are occupational, pertaining to jobs with an inability to work from home, or socioeconomic such as living in more dense areas that limit families' ability to socially distance. Unless these root causes of health-related disparities are addressed, efforts toward reducing comorbidities alone will minimally diminish the impact of health crises like COVID-19. As trainees and future healthcare leaders, we must be patient and be public health advocates battling these systemic inequities head on. ■

References

1. Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases. COVIDView: a weekly surveillance summary of the U.S. COVID-19 activity. Updated September 4, 2020. Accessed September 7, 2020. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
2. Feldstein LR, Rose EB, Horwitz SM, et al. Multisystem inflammatory syndrome in U.S. children and adolescents. *N Engl J Med.* 2020;383(4):334-346. doi:10.1056/NEJMoa2021680

In November 2011, a large team from Vanderbilt University led by James L. Netterville, MD, traveled to Malindi, Kenya, for a medical mission. An overhead shot captured the dedicated activity of the Tawfiq Hospital operating room.

Dedicated to Serving Underserved Patients with ENT Care

> One of my greatest rewards is following the lives of these doctors—my 'academic children'—and seeing the remarkable differences they are making here and around the world.

James L. Netterville, MD, has been with the Department of Otolaryngology at Vanderbilt University Medical Center since 1986. As the Mark C. Smith professor of otolaryngology and director of the Division of Head and Neck Surgery, he promotes education and research in both voice disorders and head and neck oncologic surgery, his specialty. In addition, he is the associate director of the Bill Wilkerson Center for Otolaryngology and Communication Sciences.

During his tenure at Vanderbilt University, Dr. Netterville has mentored and trained nearly 150 residents and 54 head and neck fellows who specialize in head and neck oncology and reconstructive surgery. "One of my greatest rewards," he said, "is following the lives of these doctors—my 'academic children'—and seeing the remarkable differences they are making here and around the world. Some are vice presidents, some are chairpersons, many are division directors, but all of them are in the trenches of providing excellent patient care. They all are a true inspiration to me as I watch their lives, rearing their families—'my academic grandchildren'—and hearing stories of the exemplary care they provide to their patients."

In 1998 Henry Farrar, MD, the founder of the Nigerian Christian Hospital, contacted Dr. Netterville about helping to treat his severely underserved patients in Nigeria. This led to the founding of **More Than Medicine,** a medical team of board-certified otolaryngologists, anesthesiologists, pathologists, nurses, operating room techs, and speech pathologists. More Than Medicine, in partnership with the Caris Foundation, has established surgical camps in

Africa and Haiti, where they provide medical education to regional ENT surgeons and treat underserved communities with free healthcare.

"During the first trip to Nigeria in 1999, there were only six team members, including only one other surgeon, my resident-mate and lifelong friend, **Dr. Walter Cosby**," he recalled. "We performed 100 advanced head and neck surgical procedures with no cautery or suction, operating with camping headlights during the frequent power outages. To evacuate bleeding during the procedure, the surgeon, balancing on one foot, would manually activate a small foot pump by pumping up and down on the pedal to create a weak surgical suction, all the while performing the delicate surgical procedure."

Today, Dr. Netterville and his brother, J. David Netterville, MD, a Vanderbilt University anesthesiologist, continue to lead surgical outreach teams, which have expanded to 25 medical professionals based primarily in Nashville, Tennessee. In partnership with the regional university head and neck surgery programs, the teams serve rural Nigeria, Kenya, and Haiti.

In 2004 Dr. Netterville received the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) Distinguished Award for Humanitarian Service, an award recognizing an Academy member who is widely known for a consistent, stable character distinguished by honesty, zeal for truth, integrity, love and devotion to humanity, and a self-giving spirit. The awardee is an outstanding example and model to emulate for a life dedicated to a nobler, more righteous, and more productive way of life.

After graduating from Lipscomb University, Dr. Netterville attended the University of Tennessee College of Medicine, becoming "extremely inspired by the depth and breadth of otolaryngology." Later during a fellowship at the University of Iowa, training under senior professors in the specialty, he was inspired to focus on a career in academic medicine. "Early in my career, I was privileged to work with and learn from some of the real giants in the field of otolaryngology, doctors in both clinical and academic medicine. They all had big hearts and wanted to make a difference in the world. It was not about pride and ego for them—it was about doing something new and creative to advance patient care. They opened my eyes to the direction I should follow."

In 1983 Dr. Netterville attended his first AAO-HNSF Annual Meeting as a third-year resident. "The Academy was the pinnacle of education in the world, and it still is. I was astounded by the amount of educational opportunities I saw; it was like a Niagara Falls of information washing over me, and I just couldn't absorb it all. That experience made me excited to be part of the Academy, and I sought out every opportunity to be on committees and then take on committee leadership."

He eventually served for three years on the AAO-HNS/F Board of Directors, where he witnessed the "amazing dedication of non-paid otolaryngologists who were giving up their time to travel back and forth to Washington, DC, to forward the needs and goals of the Academy." After his time on the Board, Dr. Netterville was elected to and served as President of the Academy from 2012 to 2013. "Being President was one of the greatest honors of my life," he said.

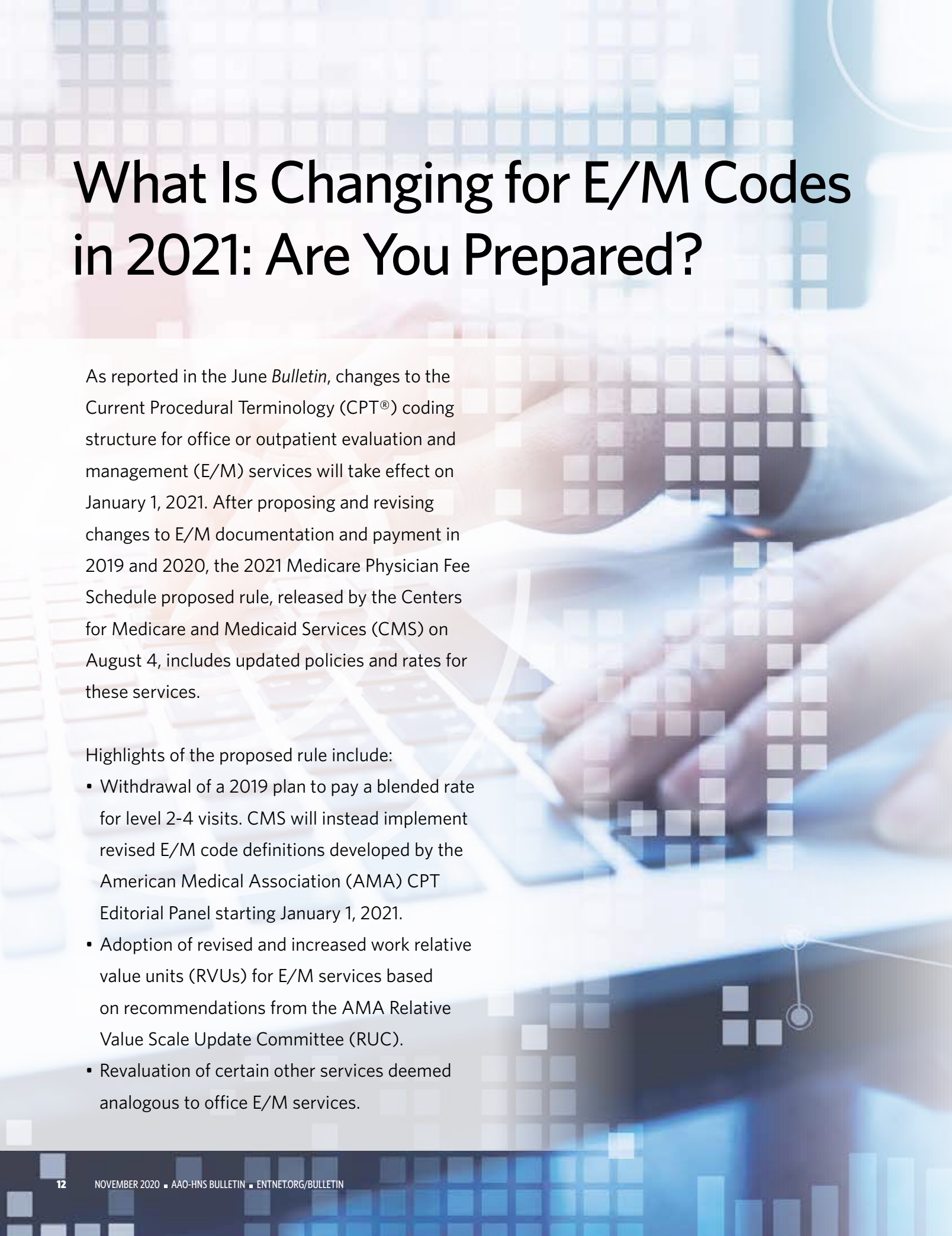
During his time on the Board and as President, global education was beginning to take greater strides, thanks to support from the Academy. Given his passion for humanitarian service, Dr. Netterville sought to add more global education opportunities at the Annual Meeting and encouraged physicians from around the world to attend, particularly those in low- to middle-resource countries. He also helped to create non-physical methods of engagement, such as targeted podcasts.

In addition to the Distinguished Award for Humanitarian Service, Dr. Netterville has received numerous honors throughout his career, including the 2009 AAO-HNS Board of Governors Practitioner Excellence Award, the 2009 Outstanding Alumnus Award from the University of Tennessee Health Science Center College of Medicine; the 2012 Joseph H. Ogura, MD, Lecturer from the Triological Society; the 2013 deRoaldes Fund & Award from the American Laryngological Association; the Candle Award for Teaching and Mentoring from the Vanderbilt University School of Medicine; and the 2010 5-Star Patient Satisfaction Award for Overall Quality of Doctor Care from Professional Research Consultants. He has been an honored guest and medical consultant in countries around the world, including Australia, Chile, Cyprus, Egypt, Italy, Mexico, Oman, Saudi Arabia, South Africa, Spain, Sweden, Taiwan, Thailand, and Turkey.

"It has been a privilege to participate in various aspects of our Academy's leadership, education programs, and education outreach. My involvement in the Academy has opened so many doors of opportunity for me that I could not have accessed on my own. As a direct result of Academy meetings and activities, I have developed many deep relationships that have truly blessed my life. When I retire someday, I would like to take my wife, Mitzie, who has put up with me for 43 years, pack up a camper, and travel around the country to share a cup of coffee with so many dear friends and colleagues whom I have come to know and love. I value the time we are able to spend together, safely, sharing our experiences and respect for each other." ■

In June 2020 the AAO-HNS shared a special message for the 2020 otolaryngology resident graduates. Dr. Netterville contributed his well wishes as an AAO-HNS/F Past President in this special tribute.

What Is Changing for E/M Codes in 2021: Are You Prepared?



As reported in the June *Bulletin*, changes to the Current Procedural Terminology (CPT®) coding structure for office or outpatient evaluation and management (E/M) services will take effect on January 1, 2021. After proposing and revising changes to E/M documentation and payment in 2019 and 2020, the 2021 Medicare Physician Fee Schedule proposed rule, released by the Centers for Medicare and Medicaid Services (CMS) on August 4, includes updated policies and rates for these services.

Highlights of the proposed rule include:

- Withdrawal of a 2019 plan to pay a blended rate for level 2-4 visits. CMS will instead implement revised E/M code definitions developed by the American Medical Association (AMA) CPT Editorial Panel starting January 1, 2021.
- Adoption of revised and increased work relative value units (RVUs) for E/M services based on recommendations from the AMA Relative Value Scale Update Committee (RUC).
- Revaluation of certain other services deemed analogous to office E/M services.

Practitioners and billers need to know that the new E/M codes include revisions to the CPT descriptors for codes 99202-99215 and documentation standards. Additionally, in the proposed rule, CMS extends some of the telehealth flexibilities enacted during the COVID-19 public health emergency (PHE).

Major E/M changes for 2021 include:

- Eliminating history and physical exam as elements for code selection.
- Allowing physicians to choose whether their documentation is based on medical decision making (MDM) or total time on date of service.
- Modifying MDM criteria to move away from simply adding up tasks to focusing on tasks that affect the management of a patient's condition.

The new documentation requirements will be based on the traditional format of subjective, objective, assessment, and plan in which physicians document what the patient was there for (subjective), what was learned from their history and exam (objective), what the physician assessed to be the problem, and the plan for resolving it.

Beginning in January, physicians will have a choice between whether their documentation will be based on MDM or total time. The regulations define "time" as minimum time, not typical time, and this represents total time on the date of service. This definition builds on the movement over the last several years by Medicare to recognize the work involved in non-face-to-face services such as care coordination. There is a limitation on this definition as it only applies when code selection is primarily based on time and not MDM.

MDM

If MDM is used to determine the E/M code for the outpatient visit, the factors a physician must weigh depend on site of service. If the evaluation is in the office setting, the factors in MDM include number and complexity of problems addressed, amount and/or complexity of the data reviewed and analyzed, and risk of complications and/or morbidity of patient management. If the evaluation is in an inpatient setting, factors include number of diagnoses or management options, amount and/or complexity of data to be reviewed, and risk of complications and/or morbidity. Additionally, evaluation and billing for inpatients has not changed.

Time

If time spent on the encounter is used as the determinant for the CPT code billed, the time values will change next year from typical time used to total time used. CPT code 99201 will be deleted, effective January 1, 2021. For new patient codes, times begin at 15–29 minutes for CPT code 99202 and then advance in 15-minute increments with 99205 assigned 60–74 minutes. For existing patients, the time element was removed from CPT code 99211. For CPT code 99212, time for the encounter will be 10–19 minutes. Ten-minute increments are used for codes 99213 and 99214. CPT code 99215 has a 15-minute time frame and is utilized for exams 40–54 minutes in duration.

If these time frames do not reflect enough time to describe the encounter, there will be a new code for CPT codes 99205 and 99215 for those reporting based on time. Code 99417 will be used in 15-minute increments when the visit takes longer than the times allowed in the new codes. Prolonged services of less than 15 minutes should not be reported. Code 99417 can be reported multiple times for the same visit. For example, if an encounter takes 90–104 minutes, 99205 should be reported in addition to 99417 being reported twice.

CPT Code 99358

There is an additional CPT code, 99358, that should be utilized for non-face-to-face encounters, usually telehealth, and therefore should not be reported on days when other E/M codes are reported.

Telehealth

The rule includes proposed policy changes to maintain certain elements of the various telehealth flexibilities authorized on a temporary basis during the COVID-19 public health emergency, with some proposals lasting until December 31, 2021, or the end of the calendar year (CY) in which the public health emergency ends, whichever is later. The services CMS is proposing to add to the Medicare telehealth list include GPC1X - Visit Complexity Associated with Certain Office/Outpatient E/Ms, 99417 – Prolonged Services; 99334, 99335 – Domiciliary, Rest Home, or Custodial Care Services; and 99347, 99248 – Home Visits.

CMS is not proposing to continue separate payment beyond the public health emergency for the audio-only telephone E/M services established in the March 31 COVID-19 interim-final rule. However, the agency is seeking feedback on developing coding and payment for such a service. CMS is also proposing to allow direct supervision to be provided using real-time, interactive audio and video technology (excluding telephone that does not also include video) through December 31, 2021. Some private payers have shown interest in making the telehealth changes adopted for the PHE permanent.

The telehealth proposals are subject to change. Any permanent policy changes will be implemented in the Physician Fee Schedule final rule, which is expected to be released around the same time that this article is published. Due to the COVID-19 pandemic, CMS has waived the 60-day delay in the effective date of the final rule and replaced it with a 30-day delay. This means that the final rule will be effective January 1, 2021, even though it may not be published until December 1, 2020.

Check the *Bulletin* early next year for another update on these and other policies included in the CY 2021 Medicare Physician Fee Schedule that impact the specialty.

Visit the Academy's Coding Corner, **https://www.entnet.org/content/codingcorner**, for additional updates on the revised E/M codes, as well as the newest coding and reimbursement tools for members. ■

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Perspective: The Replacement of Medicare Carrier Advisory Committees Is a Replacement of the Physician Voice

Note from the *Bulletin* Editor

James C. Denneny III, MD

I must admit that when **Steve T. Kmucha, MD, JD,** sent me this comprehensive historical review of the Carrier Advisory Committees (CAC) all the way through their demise, it brought back many good memories of my many years on the Tennessee CAC. Even though I had to drive three hours each way from Knoxville to Nashville, there was no question in my mind that that committee did a lot of good things for physicians and their patients. The open discussions between practicing physicians and administrative leaders were not contentious in those days and, for the most part, the collaborative solutions benefited all involved. That appointment ended up being one of the most important I have ever received. I learned more about the inner workings of the Health Care Financing Administration (now Centers for Medicare & Medicaid Services) and other insurers from that service than any other I have experienced. I was very disappointed to learn that the CACs have been phased out.

The CACs were one of the great examples of how critical it is to have practicing physicians—not just physicians who now work in alternative roles—involved in decision-making processes regarding patient care. No matter how objective one is, the main focus is not the same for those no longer seeing patients. The biggest loss in the transition is that element being required in all areas. One of the reasons the physician community fought so hard against the Independent Payment Advisory Board as described in the Affordable Care Act was that there was no true practicing physician representation on that body. Those of you who have opportunities to participate on a panel such as this should take advantage of them, even though it does take additional time and effort. This is one of the few areas in which individuals can make tangible differences in health policy.

Steve T. Kmucha, MD, JD

Steve T. Kmucha, MD, JD

In 1992 the Health Care Finance Administration (HCFA), part of the U.S. Department of Health and Human Services (HHS), directed the nation's Medicare Carrier Medical Directors (CMD) to establish Carrier Advisory Committees (CAC). CACs, which were generally geographically located in each state or region, were tasked with providing: 1) a formal mechanism for physicians to learn about and participate in the development of local medical review policies (LMRPs), 2) a means for identifying areas within the administration of the Medicare program that need improvement and for overcoming those challenges, and 3) a forum for exchanging information between physicians and carriers.

To ensure that LMRPs are examined by clinical experts for each type of service being reviewed, the CMDs were required to appoint CAC representatives for Medicare's expansive definition of physician specialties as well as dentists, chiropractors, podiatrists, optometrists, and psychologists, along with any other provider allowed to bill Medicare directly.

The Medicare carrier manual instructions establishing the CACs stated that "CAC members serve to improve the relations and communication between Medicare and the physician community." Specifically, physicians serving in this position are tasked with 1) disseminating proposed LMRPs to colleagues in their respective states and specialty societies to solicit comments, 2) distributing information about the Medicare program obtained at CAC meetings to their respective state and specialty societies, and 3) discussing inconsistent or conflicting medical review policies within the CAC.

It is important to emphasize the role of physician attendance at CAC meetings as 1) they are required to receive a full agenda and background material at least 10 to 14 days prior to a CAC meeting to allow adequate preparation and contribution, and 2) all CAC representatives have the opportunity to review each draft LMRP and critique them. As a result, physician CAC representatives

have long been identified as important resources for the Medicare Administrative Contractor (MAC) medical directors. More importantly, physician CAC representatives have the opportunity to provide feedback about draft policies and thereby have the opportunity to influence Medicare coverage.

In the past, many MAC medical directors have emphasized the importance of physician participation on the CACs. Prior to the implementation of the CACs, numerous policies were developed independently by regional MACs with inconsistent input from only a few physician consultants. CACs were touted as providing an opportunity to offer MACs a broad base of consultants, each of whom has a slightly different perspective. It was warned that those physicians who fail to participate as active and engaged representatives of their geographic or specialty society could contribute to "unenlightened coverage decisions."

Each CAC submitted testimony to the regional MAC, and the medical director of the regional MAC submitted recommendations to a national Medicare Coverage Advisory Committee (MCAC). The MCAC would summarize the recommendations of the regional MACs and make recommendations to HCFA. HCFA could then adopt or disagree with the MCAC recommendations and issue a national medical review policy (NMRP) or leave the service to be covered at the discretion of the regional MACs based upon the established LMRP in those regions. In 2000 it was estimated that 90% of Medicare coverage decisions were covered only by LMRPs without a corresponding uniform NMRP; this supported the importance of active participation of each physician representative at the local CAC.

Fast forward to 2018, many things had changed at the HCFA and with the Medicare program. The HCFA is now called the Centers for Medicare & Medicaid Services (CMS) but remains an agency at HHS, which administers the Medicare program—the federal component of the Medicaid program—and oversees Medicare's healthcare financing.

During 2018, HHS Secretary Alex Azar worked to achieve amendment of 42 U.S.C. 217a, section 222 of the Public Health Service Act. This amendment resulted in the creation of a revised Medicare Evidence Development & Coverage Advisory Committee (MEDCAC), which is governed by the provisions of Public Law (P.L.) 92-463 that sets forth the standards for the formation and function of Medicare advisory committees. The stated objective of this change would allow the secretary of HHS, and by delegation, the administrator of the CMS and the director of the Center for Clinical Standards and Quality within CMS, to decide what medical items and services are reasonable and necessary, or otherwise covered, for Medicare beneficiaries under title XVlll of the Social Security Act. The newly established MEDCAC would provide advice to CMS regarding the evidence on topics under review by Medicare.

The explicitly stated fundamental purpose of the creation of the MEDCAC is to support the principles of an evidence-based determination process for Medicare's coverage policies. MEDCAC was envisioned to establish panels that would provide advice to CMS on the strength of the scientific evidence available for specific medical treatments and technologies through a "public, participatory, and accountable process." The MEDCAC will work from an agenda provided by the Designated Federal Official (DFO) that would list specific issues for investigation and would develop technical advice in order to assist CMS in determining reasonable and necessary uses of medical services and technology. The MEDCAC may be asked to develop recommendations about the quality of the scientific evidence for specific issues of Medicare coverage or related policies, and/or to review and comment upon proposed or existing Medicare coverage policies and the evidence upon which the policies rely. CMS may also ask the MEDCAC to comment on pertinent aspects of proposals being considered and/or other policies.

CMS Administrator Seema Verma was given the authority to select a full-time or permanent part-time federal employee to serve as the DFO to attend each MEDCAC and sub-committee meeting to ensure that all procedures are within applicable statutory and regulatory directives. The DFO will approve and prepare all meeting agendas, call all of the MEDCAC and subcommittee meetings, adjourn any meeting when the DFO determines adjournment to be in the public interest, and chair meetings when directed to do so by the official to whom the committee reports (i.e., CMS administrator). The DFO or a designee shall be present at all meetings of the full committee and subcommittees.

The language of the amended Title states that the MEDCAC shall consist of a maximum of 100 members who will be appointed as special government employees or representatives. Members shall be selected by the CMS administrator, or designee, from among authorities in clinical and administrative medicine, biologic and physical sciences, public health administration, advocates for patients, healthcare data and information management and analysis, the economics of healthcare, medical ethics, and other related professions. A maximum of 90 members shall be at-large standing members (10 of whom are patient advocates) and 10 shall be members representing industry interests. The administrator or designee will appoint a chair and vice-chair from among the pool of at-large members.

Members shall be invited to serve for four-year terms. Terms

of more than two years are contingent upon renewal of the charter. Members may serve after the expiration of their terms until successors have taken office. The period of service for the chair and vice chair shall be for no more than four years. The Agency may adjust terms of membership to ensure that MEDCAC member terms expiring do not exceed 25% per year. A panel roster will be developed and published in advance for each MEDCAC meeting. Members will be chosen to serve at each MEDCAC or sub-committee meeting according to their expertise and the topic to be discussed.

The panel roster for each MEDCAC or sub-committee meeting will be comprised of the standing chair (or standing vice chair) who will preside, or in their absence, an interim chair delegated by the CMS administrator or designee, one industry representative, and one patient advocate. The remaining members of the panel roster will be chosen from the standing pool of at-large members. There will be no more than 15 MEDCAC members serving at a particular meeting. A quorum is required for all meetings and shall consist of a majority of the members designated for service at each meeting. In addition to the committee members, the committee may include guests whose expertise pertains to the meeting topic. This final decision was published in the Federal Register on November 24, 2018.

Soon after this final decision was published, the regional MAC medical directors were informed that there would be little need to convene regional CACs. In some regions, a decision was made to replace the formal CAC process with the Informal Medicare Physician Advisory Council (IMPAC) process comprised of nearly the same individuals who had been previous members of the formal CAC process. IMPAC meetings have continued during the interim. This has effectively removed the regional physician members of the CACs and the MAC medical directors from the policy development process and limited the decisions and the resulting impact on physician payment to a few handpicked individuals with MEDCAC meetings, agendas, and member compositions controlled by a direct appointee of the CMS administrator—a political appointee. Of a maximum of 100 members of the MEDCAC, 10% are allocated to patient advocates and an additional 10% are allocated to industry representatives. Meetings of the MEDCAC are limited to just 15 members—members who are selected by a handpicked federal employee who is similarly handpicked by Administrator Verma, and thus potentially excluding the input of many physician groups.

The current roster of MEDCAC members was established in November 2019. A review of this roster shows significant representation from some medical specialties (e.g., cardiology, cardiac surgery, neurosurgery, etc.) and no representation from many others. It is clear that the voices of many physicians and many medical specialties have been excluded from the process. It is also clear that these changes have transferred a great deal of power and authority away from the physicians of the CAC and the MAC physician medical directors. The new charter placed this power in the hands of a very small number of individuals, many of whom are not physicians and many of whom represent industries with significant potential to gain financial benefit from the decisions made by the MEDCAC. And all of whom were never elected to their positions but only serve as appointees.

Recently, there has been a significant change in the impact of the resumption of many new pre-authorization requirements from Medicare for many of the most common procedures performed by otolaryngologists. Since physicians in general and otolaryngologists specifically have been excluded from the process and replaced with patient and industry representatives by political appointees, is anyone surprised? ■

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Spotlight: Humanitarian Efforts

Chad A. Zender, MD

The Spotlight on Humanitarian Efforts recognizes AAO-HNS members who are contributing their time and expertise to otolaryngologic patient needs around the globe. These individuals demonstrate integrity and devotion to humanity through a self-giving spirit. They are outstanding models to emulate in fostering a global otolaryngology community. For this spotlight, the AAO-HNSF International Affairs Program would like to spotlight **Chad A. Zender, MD,** for his work with Head and Neck Outreach (HNO).

Where do you currently practice and what is your specialty area?

In 2019 I started my clinical and administrative work at the University of Cincinnati College of Medicine as a professor in the Department of Otolaryngology, along with several various leadership roles, including the Center of Excellence co-leader for head and neck cancer, University of Cincinnati (UC) Cancer Center, and as an associate chief medical officer for UC Health. My areas of specialty include head and neck cancer, head and neck reconstructive surgery, and endocrine surgery.

What humanitarian programs are you involved with, and what do they do?

I am currently the president of a nonprofit organization called Head and Neck Outreach (HNO). I helped start this organization in 2014 after developing a collaborative program with Dr. Jeff Otiti and the Uganda Cancer Institute and Case Western Reserve University directed toward improving care for patients with head and neck disease through physician, resident, and nurse training. Over six years have passed since our first trip, and the organization remains committed to improving head and neck healthcare in developing countries through sustainable education, research, and surgical program development. To this end, HNO has facilitated care for over 400 individuals in Uganda, resulting in over 225 complex head and neck surgical procedures. The teams have consisted of over 70 surgeons, nurses, residents, and students from across the U.S. who are committed to the development of head and neck care globally. Over 3,500 pounds of necessary medical equipment and supplies have been hand-carried and delivered to Kampala, Uganda, in order to outfit the surgical space and allow the local surgeons to continue care even after the teams return to the U.S.

What got you started in committing your time and practice to humanitarian efforts?

I worked in the office of community outreach in college, both as a volunteer and then as an employee, which certainly stirred my interest. However, it was not until my fellowship that I shared an experience with **Dr. James L. Netterville** and traveled to Nigeria with his well-established international outreach program. It truly changed my life and perspective as a young man from a small town in Ohio, seeing the impact you can have far beyond what you think is possible. He has become a dear friend, and I will always be indebted to him for that gift.

How does your work impact the communities you serve, and how does it impact you as a person?

Partnering with Dr. Jeff Otiti, Nurse Christina Tino, Dr. Ian Bwete, and other local clinical staff over the past six years has expanded the surgical care delivered at the Uganda Cancer Institute. We see ourselves in a supportive role helping them to care for the patients in their region with education, equipment, and technical support. The education piece has been a wonderful aspect of our work, working with residents from Makerere University on each of our trips.

Personally this work keeps me grounded and reminds me of how fortunate I am to care for patients every day. We can lose sight of

our true purpose with administrative duties, paperwork, new policies, and other necessary distractors. The sacrifice and effort this work requires help to remind me that as a physician the "other" work should always take us back to our patients. The administrative work we do is a means to an end and should always focus on creating viable healthcare systems that can provide the best care possible for our patients.

What would you say to encourage others to support humanitarian efforts around the world?

The sacrifice and effort this work requires help to remind me that at the center of all this is our patients. I see over and over the positive impact on young adults when they are taken outside of their daily comforts and able to recognize how fortunate we are to live in the United States. For those who are more seasoned, humanitarian efforts have a way of providing a refreshing and new perspective on our daily work.

Any other final comments or thoughts?

As I am preparing for trips and feeling overwhelmed, I have asked myself on several occasions, "Why am I doing this?" That feeling of purpose is what continues to drive the work, and hopefully after a turbulent 2020, we can get back to our colleagues and friends in early 2021. ■

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Childhood Impressions Set the Path for Lifelong Experiences and Contributions

Eugene N. Myers, MD, FRCS Edin (Hon)
Past President of the AAO-HNS/F and
first AAO-HNSF International Coordinator

My life has always had an international flavor. Both sets of grandparents came from Europe in the early 20th century, and my father's parents never learned to speak English. Family affairs, particularly at the holiday season, were very old world. My dad, Dr. David Myers, was chair of the Department of Otorhinology at Temple University School of Medicine. In the mid-1950s, he became one of the leaders in the recently introduced stapes surgery for otosclerosis deafness, and our house was always filled with visiting doctors who came to learn stapes surgery from him from such diverse places as Brazil, Australia, and the UK. The exposure to this exciting group motivated me to go into medicine to become a stapes surgeon and do this miraculous surgery and make people hear. The otorhinology residents that I met came from the world over but particularly from Latin America and Mexico. As a medical student at Temple, I spent a lot of time with these visiting trainees and really admired this group of highly energetic and enthusiastic individuals who came to learn our specialty at Temple.

After I completed my residency at the Massachusetts Eye and Ear Infirmary, I spent two wonderful years as a Captain in the U.S. Army at the 97th General Hospital in Frankfurt, Germany. Lieutenant Colonel Harry McCurdy, who was the senior ranking otolaryngologist in the U.S. Army and the consultant to the Surgeon General, was responsible for making assignments. I met him previously and requested to be stationed in Europe. LTC McCurdy had been stationed in Frankfurt at one time and thought that I would be well suited for a large general hospital in Europe so that when I was not working hard taking care of the military personal and their families, I could enrich myself and my family with travel throughout Germany and neighboring countries. In fact my family and I visited virtually every country in Western Europe and had the opportunity to experience various cultures, languages, food, and entertainment. This was an unparalleled opportunity to learn how to meet people of other nations. It also set the stage for me to engage in international outreach throughout my academic career.

I became the first member of the academic faculty as well as the chair of the Department of Otolaryngology at the University of Pittsburgh in 1972, where I inherited a group of residents from around the world, including Greece, Egypt, and India. In 1981 Dr. Lee, an otolaryngologist from Taiwan, became our first International Visiting Scholar (IVS). In the ensuing years, we have welcomed several thousand otolaryngologists from around the world to our department to study with our talented faculty and to learn our philosophy of managing patients and our surgical techniques so that they could better care for their patients when they returned to their home countries. When I was operating, I always had a dozen or so IVSs breathing down my neck, observing the surgical techniques, taking notes, making drawings, or taking pictures. The interaction—both medical and social—with these doctors, and often their families, was a remarkable experience for all concerned and made a deep impression on me and motivated me to do more.

As a new fellow of the AAO-HNS in 1966, I was almost immediately drawn into committee work. I was recruited to become the U.S. representative to the Pan-American Committee of Otolaryngology-Head and Neck Surgery by my good friend Dr. J. Ryan Chandler, who was chair of the Department of Otolaryngology at the University of Miami School of Medicine. Very few of our AAO-HNS members were interested or even knew about the Pan-American Committee. I became president of the Pan-American Association in 1988, and during my two-year term I presided over the congress held in Buenos Aires, Argentina. This was an unforgettable experience highlighted by a mini revolution orchestrated by one of the generals involved in the junta that killed countless political opponents. In 1986 I participated, under Dr. Tony Maniglia's leadership, in organizing the International Federation of ORL Societies World Congress, and from 1992-1994 I served as Chair of the AAO-HNS Committee for Latin American Medicine.

In 1995 when I served as President of the AAO-HNS, our organization recognized the need for a coherent international program, and in 1996 at a strategic planning meeting of the Board of Directors (BOD), the recommendation was put forth to create a Department of International Affairs. This action was unanimously endorsed, and I was offered the position of Coordinator of International Affairs. Since international travel to lecture, operate, and build relationships with international colleagues were passions of mine and since I was already known as "Dr. International," it took only a nanosecond for me to accept the appointment. The BOD unanimously approved the appointment, and the rest is history. I was very excited about embarking on a new adventure, which I knew would be helpful to the AAO-HNS and its international colleagues.

My goals for this new program included providing for our international colleagues' education and service that had not been available previously and to do everything possible to make them feel welcome at the AAO-HNSF Annual Meeting—and, of course, to make corresponding membership look attractive to them. It was hoped that this new set of international members

would offset the declining domestic membership, which had resulted from many of our members taking early retirement as a response to the transition to managed care in the 1990s. This outreach also provided a unique opportunity to tap into a large pool of talented and diverse academic leaders and faculty who continue to participate in the education offerings of the Annual Meeting, as well as AAO-HNSF Joint Meetings.

To accommodate and welcome our international colleagues at the Annual Meeting, we focused on providing greater accessibility for our visitors in a number of areas. We recruited interpreters for multiple languages to prevent bottlenecks at the registration desk, identified affordable hotels and included these hotels on the shuttle bus routes to eliminate expensive taxi rides, and established Panel Presentations and Expert Lectures in Spanish, one of the most common spoken foreign languages.

Since I had many friends who belonged to overseas chapters of the American College of Surgeons (ACS), I researched the ACS program and used some of the strategies they had developed to establish overseas chapters in our International Program. During our Annual Meeting in San Francisco, California, in 1997, I invited four of my closest international friends to a breakfast meeting: Professors William Wei (Hong Kong), **Emanuel Helidonis** (Crete), Carlos Suarez (Spain), and Chong Son Kim (Korea). I explained our new program in detail, including overseas chapters, which would have clearly defined goals and benefits. At the end of the meeting, they asked me if they were to be included as the original chapters. It was unanimous—they were in!

The AAO-HNS was advised that the word "chapters" could not be used so the term International Corresponding Society (ICS) was substituted. More important than the name were the guidelines that I developed for the function of the ICS. For example, the ICS should be the national society of that country, and a Joint Meeting with AAO-HNSF should be held every three years. I asked each ICS to appoint the editor of its national journal to be a member of a newly organized International Editorial Board of our journal, *Otolaryngology-Head and Neck Surgery*, and to appoint one of its members to be a nonvoting delegate to our Board of Governors. We also added a well-received social networking event to the Annual Meeting with the International Reception.

Catherine Lincoln worked with me as the Director of the International Program for 17 years. Her parents had been career diplomats, and she had been born and lived outside of her native UK. She had a deep understanding of the needs of our overseas colleagues, but it was her charm, winning smile, and the great personal interest that she took in the work of the program that drew crowds around her at the AAO-HNS booth, whether in the United States or abroad. Rebecca Dobbins, who has been the Director of Global Affairs for the past four years, has a wonderful, cheerful, can-do attitude and has made a tremendous impression and impact on our International Program through the productive manner in which she interacts with our overseas colleagues. There are now 75 ICSs so she really has her hands full. There were 20 Joint Meetings scheduled for 2020, in locations ranging from Antigua to the UK. All but a few have been canceled, rescheduled, or reformatted by video conferencing technologies such as Zoom and WebEx into virtual meetings. I participated in several of these that were quite good and a tribute to Rebecca's and the AAO-HNS's flexibility.

Much of the success of the International Program must be attributed to the series of very successful Coordinators of International Affairs, including **K.J. Lee, MD, Gregory W. Randolph, MD, James E. Saunders, MD,** and **J. Pablo Stolovitzky, MD.** Each one has left an indelible imprint on the International Program with their strong leadership and each continues to be active in the AAO-HNSF International Program committees. **Mark E. Zafereo, Jr., MD,** who has considerable overseas experience with the AAO-HNS/F, is now the Coordinator-Elect of International Affairs. The AAO-HNS leadership has been enormously supportive of the International Program. Regional advisors have been appointed and are actively working with the ICSs in their region. For example, I am the regional advisor to the Balkans and have been the honorary president of the Balkan Society of Otolaryngology-Head and Neck Surgery since its reorganization in 2001.

James C. Denneny lll, MD, Executive Vice President and CEO of the AAO-HNS/F, has provided tremendous support for the International Program. There are now approximately 1,100 corresponding members of the AAO-HNS. In order that their voices could be better heard, the International Advisory Board was established with **Johannes J. Fagan, MBChB, FCS(SA),** of the University of Cape Town, South Africa, as the founding Chair; **Sady Selaimen da Costa, MD, PhD,** from the University of Rio Grande do Sul in Brazil, who served as Chair from 2019-2020; and now **Professor Karl Hoermann, MD,** of Mannheim, Germany, who started his term as Chair in September 2020.

AAO-HNSF 2019 Annual Meeting & OTO Experience: During the International Advisory Board General Assembly, it was a rare moment to capture all the individuals who have served as AAO-HNSF Coordinator for International Affairs to date. From left to right are Eugene N. Myers, MD, FRCS Edin (Hon); K J Lee, MD; Gregory W. Randolph, MD; James E. Saunders, MD; and J. Pablo Stolovitzky, MD.

Overall it has been enormously gratifying to have been the "Founding Coordinator of International Affairs" and to be able to witness the major positive impact this program has had for the AAO-HNS, our international colleagues and their patients, and for me personally. There's still a lot of room for growth of the International Program, and it may be that the video conferencing technology will have a positive impact in facilitating Joint Meetings, while decreasing the expense and time lost in overseas travel.

I'm deeply indebted to the AAO-HNS for trusting me with the responsibility for developing their International Program, and I feel very fulfilled in having catalyzed its evolution to become an international education powerhouse. ■

INTERNATIONAL ADVISORY BOARD

Vision and Goals

Karl Hoermann, MD, PhD

Karl Hoermann, MD, PhD, IAB Chair

From 1993 to 2017 I served as head and chair of the Department of Otorhinolaryngology, Head and Neck Surgery (ORLHNS) and Sleep Centre at the Mannheim University Teaching Hospital in Mannheim, Germany. Following this I became head of the International Patient Office at the same hospital. Since I was appointed Chair-elect of the AAO-HNSF International Advisory Board (IAB) at the AAO-HNSF 2019 Annual Meeting & OTO Experience in New Orleans, Louisiana, I have concentrated my work besides patient care and surgery on this task.

One of my special interests is in the surgical and nonsurgical treatment of sleep-related breathing disorders, where I have been fortunate enough to gain extensive experience in a wide variety of advanced sleep surgeries.

I have had the privilege of being a fellow of the American Head & Neck Society as well as an active member of many societies, such as the AAO-HNS and the Japanese Broncho-Esophageal Society, as well as an honorary member of national ORL societies throughout Europe. It has also been my honor to be invited to present the Eugene N. Myers, MD International Lecture on Head and Neck Cancer at the AAO-HNSF 2011 Annual Meeting & OTO Experience in San Francisco, California, and as the JLO Visiting Professor from The Royal Society of Medicine, London.

Two decades of serving as a member, fellow, and/or president in various national and international ORL-HNS societies has shown me how effective the exchange of experiences and mutual support can be in promoting the excellence of professional standards and education and training, as well as in ensuring a strong and unified voice for medical specialists.

I was honored to receive my first invitation to the AAO-HNSF Annual Meeting & OTO Experience in New Orleans, Louisiana, in 1999, and I was immediately and deeply impressed by the wholehearted commitment to excellence across the wide range of specialities covered.

With its outstanding reputation and unparalleled scope of influence, the AAO-HNS is and will remain the ideal institution to contribute decisively to the consolidation and expansion of global relations.

I transitioned to the position of Chair of the IAB in September 2020, and my focus and vision for my term of office will be:

- Promoting the excellence of professional standards and education and training, with patient safety at the core of these standards
- Ensuring a strong and unified voice for medical specialists worldwide
- Strengthening AAO-HNS collaboration with regional organizations to increase visibility and international membership
- Encouraging and supporting regional incentives
- Increasing the outreach of AAO-HNS/F globally
- Producing guidelines and white papers online
- Fostering scientific exchange through the ENTConnect Open Forum Digest
- Promoting continuing medical education (CME)
- Advancing the latest research and leading-edge techniques
- Generating unlimited education and networking

We currently face immense challenges from the preventive and precautionary measures necessitated by the COVID-19 pandemic. This has caused the focus of our work to change tremendously. After my election and under the leadership of **James C. Denneny III, MD,** AAO-HNS/F Executive Vice President and CEO, a panel consisting of Immediate Past Chair of the IAB **Sady Selaimen da Costa, MD, MSc, PhD,** AAO-HNSF Director of Global Affairs Rebecca Dobbins, International Affairs Coordinator **J. Pablo Stolovitzky, MD,** International Affairs Coordinator-elect **Mark E. Zafereo, Jr., MD,** and I fixed an intensive schedule of travel to numerous international conferences. However, given the immediate situation the pandemic has placed us in, there can be no in-person international conferences. Virtual conferences have taken over.

The IAB has had to develop new approaches to reach out to ENTs on all continents around the globe. And in fact, this has been extremely interesting. The factor of different time zones has woken me for a Zoom roundtable with our friends from Asia at 2:00 am. I have been privileged to be a virtual guest in the home or the office of the individuals

involved. And they, of course, have been more than welcome in mine. This experience has been real life. No rushing to the airport, plane, cab, hotel—just concentrating and cooperating on the matter at hand in your own surroundings.

The AAO-HNS is rising magnificently to these challenges and embracing the opportunities provided by videoconferencing software. I am convinced that what we have learned and are still learning in this field will be of great benefit to us in future when the pandemic has finally ended. Although nothing can replace personal meetings and the exchange of ideas face-to-face, the possibility of inviting individual guest speakers, lecturers, and contributors to attend virtually may facilitate and enrich future events.

And we have all been updated with the management of the new situation:

- Lessons learned from the COVID-19 pandemic
- Priority-setting and resource allocation during a pandemic
- Impact of the pandemic on specialist training and mitigation thereof
- Ethics of refusing to put yourself in harm's way when PPE is lacking
- Teaching and training: Is remote education here to stay?
- What does training look like going forward?
- The future of international conferences and training courses post-pandemic
- Physicians as patients during the COVID-19 era: observations, insights, experiences

Working closely with you to ensure the continued development and success of AAO-HNS/F as we move forward is my great honor and privilege. ■

AAO-HNS Position Statement: Global Humanitarian Outreach

(Adopted January 14, 2020)

The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) recognizes that many of its members voluntarily engage in global humanitarian outreach efforts that provide humanitarian relief in crises, patient care in low resource areas, and healthcare provider education around the world. The AAO-HNS advocates that the primary objective of global humanitarian outreach efforts be the ultimate development of sustainable, autonomous healthcare within the local healthcare environment. Patient care activities within global humanitarian outreach efforts should be undertaken with local healthcare professional stakeholder input and participation in order to maximize patient care outcomes as well as educational opportunities for visiting and host healthcare teams.

Patient safety remains the top priority in patient care in low resource environments, and patients should be afforded the highest possible quality of care, with input from local healthcare providers regarding limitations in resources and cultural considerations which may impact patient care. Volunteer healthcare providers' engagement in patient care should be consistent with their skills, credentials, and practice in their normal working environment, as well as in accordance with the laws of the host country. With consistent and thoughtful collaboration between visiting and host physicians and other healthcare providers, a successful global humanitarian outreach effort ideally should eventually eliminate the necessity of its own existence.

To access the Position Statement with references, go to **https://www.entnet.org/content/position-statement-global-humanitarian-outreach.**

International Observership Directory

The AAO-HNSF maintains a directory of U.S. otolaryngology organizations or departments that offer international observerships. International observerships allow eligible international physicians the ability to shadow U.S. physicians and learn more about the specialty of their choice. Access to the directory can be found at **www.entnet.org/international.** For questions about the database or to add a U.S. otolaryngology institution to the directory, contact **international@entnet.org.**

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AAO-HNSF encourages submissions that endorse inclusion of minorities and women in the sessions, as well as topics relevant to diversity and that contribute to cultural competence for all members.

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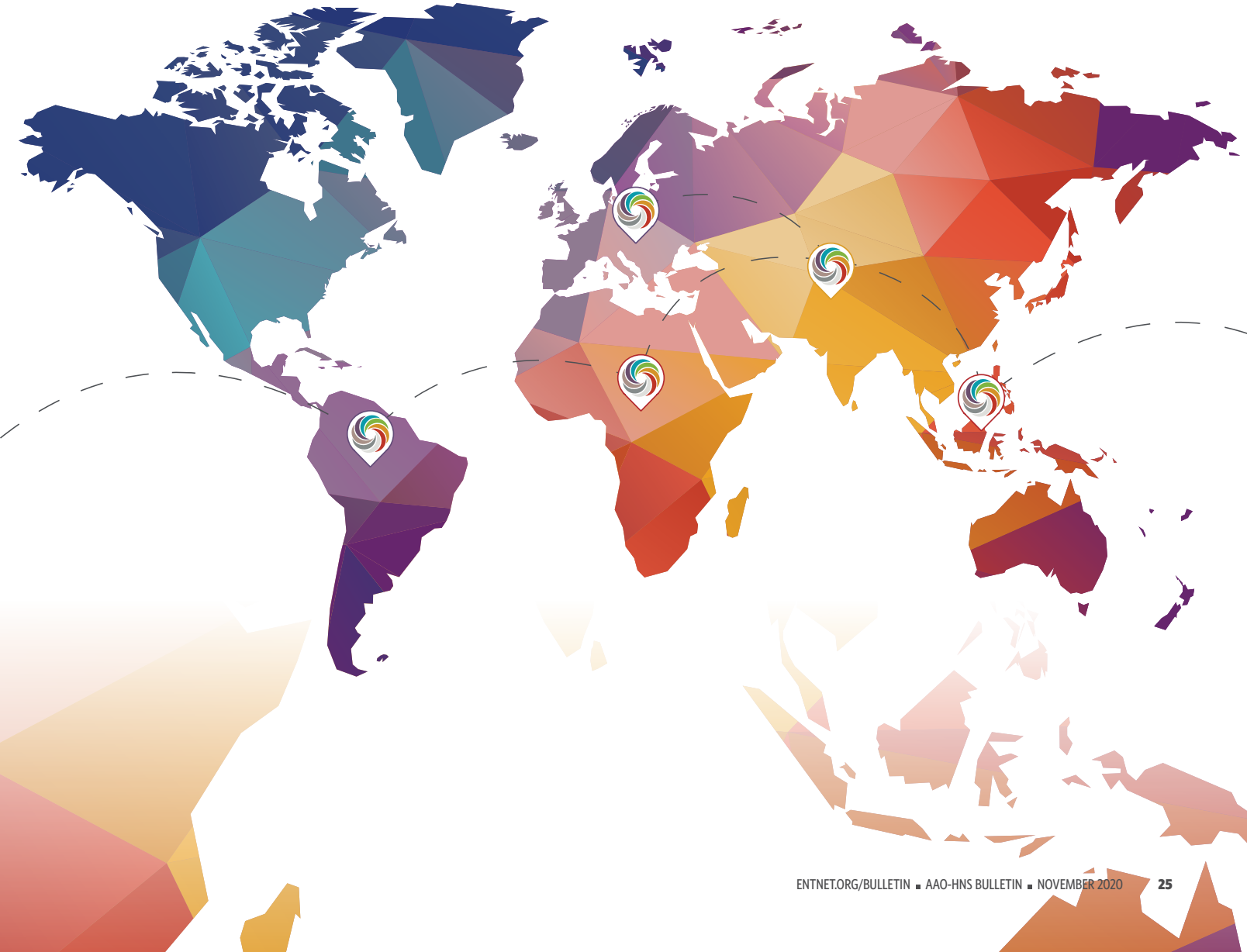

During the AAO-HNSF Annual Meeting & OTO Experience, the International Advisory Board (IAB) General Assembly includes Regional Roundtable Discussions representing Africa, Asia-Pacific, Europe, the Middle East, and Latin America. Attendees from these geographic regions share ideas, best practices, and insights on issues facing the specialty. In 2020 the Annual Meeting went virtual and so too did the Regional Roundtables. The following encapsulates a summary of the discussions from each of the five invigorating and insightful meetings, which were held in August and September.

Please note: *Due to the changing circumstances of the COVID-19 pandemic, please keep in mind that these reports are reflective of current situations as of August/ September.*

Africa

Led by Anna Konney, MD, FWACS, FGCS; with Chenge Macharia, MBChB, FCS (ECSA); **Gayle E. Woodson, MD,** AAO-HNS/F Past President; **Mark E. Zafereo, Jr. MD,** AAO-HNSF Coordinator-elect for International Affairs; and **Johannes J. Fagan, MBChB, FCS(SA),** Past IAB Chair.

The African Regional Roundtable piggybacked onto a Tumor Board Meeting of the African Head & Neck Society (AfHNS). The AAO-HNSF discussion followed clinical cancer case presentations by speakers from Cape Town, South Africa, Uganda, and Ghana. The following report was submitted by Dr. Woodson:

Returning to practice guidelines and practice changes in the COVID-19 era:

The severity of the COVID-19 pandemic, and hence its impact on clinical practice, varies greatly throughout Africa. For example, South Africa has been the hardest hit country in the continent. Other countries have been minimally affected, leading some to suggest that the disease has been under-reported. However, the clinical experience reported by participants on the call confirmed that the disease burden is relatively low in countries such as Kenya and Tanzania. Possible reasons include the youthful population, a warmer climate, and possible prior exposure to some other diseases that are not present in the West.

Training and education during the pandemic and beyond:

All participants agreed that the use of virtual meetings is a fortunate byproduct of an unfortunate situation. Otolaryngologists from Africa have appreciated the opportunity to participate in online sessions that were organized to replace in-person meetings. Participants in the Roundtable feel strongly that online education should continue and be expanded. ■

Asia Pacific

Chaired by **Sheng-Po Hao, MD,** with **Joseph K. Han, MD,** and **Elizabeth H. Toh, MD.** The following report was submitted by Dr. Toh:

Returning to practice guidelines and practice changes during COVID-19 pandemic:

Many countries have returned to seeing patients in the clinic and performing elective surgeries in June and July under the guidance of their local/regional ENT societies, hospitals, or government. Most countries have adopted a variety of engineering and non-engineering controls within their hospitals to protect patients and hospital workers. PPE recommendations vary by country to generally reflect the risk of exposure, with all using full PPE for aerosol-generating procedures. Preop COVID-19 testing was being performed in most institutions, with Japan additionally requiring patients to isolate for two weeks prior to their procedure. New Zealand requires patients to be tested for COVID-19 prior to being seen. Korea is testing all inpatients. New Zealand and Taiwan have had impressively low numbers of COVID-19 cases and related deaths during this pandemic, which they attribute to very strict government guidelines. Some countries, such as Japan, are experiencing a second wave in COVID-19 cases in metropolitan areas, necessitating local changes in policies to restrict clinical activities.

Training and education during the pandemic and beyond:

Webinars and virtual meetings were used for didactics. There was generally a reduction in patient contacts and surgical cases for trainees during the pandemic, but no changes were made to training programs except in the Philippines where training has been extended for up to one year. Exams in Singapore have been postponed, and international fellows were not allowed entry in Taiwan. Korea adopted simulation techniques for surgical training. ■

Europe

Chaired by **Maria V. Suurna, MD,** and **Cem Meco, MD, CEORL.** The following report was submitted by Dr. Suurna:

Returning to practice guidelines and practice changes in the COVID-19 era:

Each country had its own regulations guided by the government entities. European countries were faced with initial shortage of PPE, but at the present access to PPE is no longer a problem. Patient care has resumed in most countries with modifications to meet the requirements for patient and physician safety. However, in some European countries the numbers of COVID-19 cases continue to rise. As a result, many patients are afraid to come to the hospitals and seek medical care at the physician's offices, thus delaying their care. This raises a potential public health concern that patients will be presenting with more advanced medical and oncologic diseases. There is a need to find a solution for gaining patients' confidence and assuring them that it is safe to seek medical care.

Training and education during the pandemic and beyond:

Medical student education and resident training have been significantly affected. Medical education has transitioned to a virtual format, and the absence of in-person teaching, sharing practical knowledge, and development of hands-on skills is presently the main challenge for medical student education and resident training. Access to online education resources has been essential for teaching, and efforts are being made to further develop and utilize these resources. Cadaver courses have not been available during this time. During the peak of pandemic residents were not allowed in the operating rooms. In addition, the number of daily surgical cases has been significantly lower due to longer operating room turnover and time requirements between the cases. ■

Latin America

Chaired by **Jacqueline Alvarado, MD,** and **Geraldo St'Anna Druck, MD.** The following report was submitted by Dr. Alvarado:

Returning to practice guidelines and practice changes in the COVID-19 era:

Argentina experienced a long quarantine and is just now starting to return to practice following guidelines from the AAO-HNS as well as British and Spanish ORL Societies. In Brazil physicians are still being cautious, requiring preop COVID-19 testing for all surgical patients. Since the pandemic, there have been significant changes in the physician's workflow in Mexico, causing disruption, but the implementation of guidelines has allowed them to continue to work.

Training and education during the pandemic and beyond:

In Ecuador virtual learning for all the residents has been highly successful with Zoom meetings sponsored by pharmaceutical companies. At first about 300 individuals were participating, but once things went back to normal participation slowed. Colombia experienced a very long quarantine with significant hurdles to go through for education with all in-person academic activities stopped through July 2021. This has caused significant disruption in medical education. Virtual meetings are beneficial but no replacement for in-person interactions. Virtual education has also been utilized in Mexico to replace in-person events through FESORMEX (Federation of Mexican Society). ■

Middle East

Chaired by **Muaaz Tarabichi, MD,** with **Soha N. Ghossaini, MD,** and **Ahmed M. S. Soliman, MD.** The following report was submitted by Dr. Soliman:

Returning to practice guidelines and practice changes in the COVID-19 era:

Many countries in the Middle East are still in peak or have just recently reached peak. Many are still on lockdown (Iraq) while others are just beginning to open up albeit slowly (Saudi Arabia). Many are still on lockdown. Access to PPE has not been a major challenge. Egypt, for example, converted textile factories to produce PPE. Preop testing of patients for COVID-19 varies even within some countries (Saudi Arabia), where some test 100% of patients and others only test when the patient is symptomatic. Testing for healthcare workers also varied but was not routinely mandated among the countries.

Training and education during the pandemic and beyond:

Most of the otolaryngology residents were not working during the peak of outbreak, and tests and exams were postponed. Several countries noted concern about case numbers and clinical/surgical experience, and as a result, modifications of requirements were made in some countries. ■

Vaping's Harmful Effects on Our Patients

- **22.5% of high school users** and **9.4% of middle school users** reported **daily use.**
- Among current e-cigarette users, **38.9% of high school students** and **20% of middle school students** reported using e-cigarettes on **20 or more of the past 30 days.**
- **19.6% of high school students** and **4.7% of middle school students** reported **current e-cigarette use.**
- Among all current e-cigarette users, **82.9% used flavored e-cigarettes,** including **84.7% of high school users (2.53 million)** and **73.9% of middle school users (400,000).**
- During September 2014–May 2020, **total unit sales increased by 122.2% (*P*<0.05),** from 7.7 million to 17.1 million units per four week interval.

Wang TW, Neff LJ, Park-Lee E, Ren C, Cullen KA, King BA. E-cigarette Use Among Middle and High School Students — United States, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1310–1312. DOI: http://dx.doi.org/10.15585/mmwr.mm6937e1externalicon.

Ali FRM, Diaz MC, Vallone D, et al. E-cigarette Unit Sales, by Product and Flavor Type — United States, 2014–2020. MMWR Morb Mortal Wkly Rep 2020;69:1313–1318. DOI: http://dx.doi.org/10.15585/mmwr.mm6937e2externalicon.

Ofer Jacobowitz, MD, PhD

Vaping, the use of e-cigarettes or other electronic nicotine delivery systems (ENDS), has increased in recent years as compared with traditional cigarettes. There are multiple harmful effects of vaping, and for adolescents in particular, there are special concerns for harm. Despite recent regulations by the U.S. Food and Drug Administration (FDA), loopholes still exist that allow for sale of flavored ENDS devices to youth.

ENDS are battery-fueled devices that heat and vaporize liquid chemicals for inhalation. They are not combustion devices like regular cigarettes, but explosions and burn injuries have occurred because of the lithium batteries that power the heating element of ENDS. The risk is greater due to the cylindrical enclosure, improper charging in USB ports, and expanding gas within the case. Major facial burns, fractures, and loss of vision have also occurred.

Since the nicotine chambers and refill containers have a high concentration of nicotine, poisonings have occurred in children. Youth especially find the devices—often dressed in colorful, attractive packaging—alluring. Nicotine poisoning in children can result in coma, seizures, cardiorespiratory arrest, and even death.

The solvents in ENDS, propylene glycol and vegetable glycerin, chemically react with flavoring aldehydes such as those with vanilla and fruit flavors and produce noxious aldehyde acetals. These products have been shown to induce death of cultured bronchial epithelial cells, suppress mitochondrial function, and activate sensory irritant receptors. As of February 2020, lung injury (EVALI) associated with severe e-cigarette or vaping product use resulted in 2,807 hospitalizations or deaths, possibly related to some additives in the products.

The "e-liquids" in ENDS, even in absence of nicotine, have been shown to be toxic to human middle ear epithelial cell lines. Use of e-cigarettes in humans has been shown to activate inflammatory pathways and to suppress immune-related gene expression of cytokine signaling pathways, even to a greater degree than with regular cigarette smoking. E-cigarette use increases the risk of asthma attacks in youth.

Vaping may increase the risk of myocardial infarction and acutely increase blood pressure, arterial stiffness, and endothelial dysfunction in observational studies.

E-cigarette smoke may cause cancer. In mice, it induced lung adenocarcinoma and bladder urothelial hyperplasia. E-cigarette exposure in mice resulted in decreased renal filtration and increased renal fibrosis.

The use of e-cigarettes in the past 30 days was associated with a five-fold higher risk of COVID-19 infection in a survey of adolescents and young adults. Possible mechanisms may include respiratory toxicity or frequent hand-face touching in users.

Use of e-cigarettes during pregnancy can have multiple adverse effects on the

fetus, and the harm may occur prior to recognition of pregnancy by the mother. Smoking of all types increases the risk of congenital heart defects. Nicotine exposure in utero can increase the risk of childhood and adult hypertension, impair neuronal circuitry development, and is associated with preterm births and still births.

Nicotine in e-cigarettes may affect the maturing brains of adolescents, leading to disorders of emotional regulation and impulsivity. Nicotine is an addictive drug and may prime the young for addiction to other, "harder" drugs.

Menthol and fruity flavors and odorants are particularly appealing to youth and thus likely play a larger role in the vaping epidemic. In 2020 there are an estimated 3.6 million middle and high schoolers who use e-cigarettes, and eight out of 10 use flavored products. The rate has decreased from that reported in 2019, but it is still of epidemic magnitude.

Unfortunately the regulation of ENDS has not kept pace with the products. In 2016 the FDA finalized a rule to regulate the manufacture, import, packaging, labeling, advertising, promotion, sale, and distribution of ENDS. The rule also restricted the sale to those of 18 years or older. However the appeal of flavored products fueled the increased adoption and use of ENDS by youth. In January 2019 the FDA withdrew fruit-, mint -, and dessert-flavored cartridges from the market, but menthol cartridges were not included in the ban. Despite the ban, there were loopholes for open tank systems that could be filled with flavored nicotine and several companies sold disposable flavored ENDS, leading to an increase from 2.4% to 26.5% in use of these ENDS by high school students from 2019 to 2020. In June 2020 a lawsuit was filed on behalf of the African American Tobacco Control Leadership Council (AATCLC) and Action on Smoking and Health (ASH) to compel the FDA to ban menthol flavored cigarettes.

The problem remains. Let us listen to our patients and educate them about the harmful effects of vaping. E-cigarettes are like alcohol or other drugs, in a much more attractive package.

The following resources are available:

- https://e-cigarettes.surgeongeneral.gov/knowtherisks.html
- https://e-cigarettes.surgeongeneral.gov/documents/SGR_ECig_ParentTipSheet_508.pdf
- https://www.cdc.gov/tobacco/basic_information/e-cigarettes/index.htm
- https://www.cdc.gov/mmwr/volumes/69/wr/mm6937e1.htm
- https://www.cdc.gov/mmwr/volumes/69/wr/mm6937e2.htm ■

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

Advocacy in Action: Academy's Latest Anti-Smoking Efforts

The AAO-HNS supports state and federal legislation and regulations that help reduce the use of tobacco products and exposure to secondhand smoke in order to promote healthy environments and lifestyles for the public. Over the course of the past year, the Academy has worked to promote a variety of anti-smoking-related topics that have an overall impact in protecting children, youth, and adults from the consequences of tobacco and e-cigarette use.

In February 2020, the Academy along with the Tobacco Partners Coalition, worked to advance H.R. 2339, the "Reversing the Youth Tobacco Epidemic Act," through the U.S. House of Representatives. This bill would prohibit all flavored tobacco products, including e-cigarettes, increase the minimum age for purchasing tobacco products to 21, ban all non-face-to-face sales for tobacco products, and protect kids from the marketing of tobacco products. Additionally, in September 2019, the Academy sent a letter to President Trump and the First Lady supporting the Administration's plan to remove all non-tobacco flavored e-cigarettes from the market, including mint and menthol flavors, and urging the President to reject tobacco industry pleas to weaken this proposal.

More recently, on October 15, 2020, the AAO-HNS, together with 16 other medical professional societies and public health advocacy organizations, submitted an amicus brief in the U.S. District Court for the District of Columbia to uphold the FDA's ability to require graphic health warnings on cigarette packaging. The brief highlights that graphic warnings, as mandated by the FDA through the Final Rule "Required Warnings for Cigarette Packages and Advertisements," are essential for effective communication to the public about the extraordinary range of health harms resultant from smoking."

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The Great American Smokeout is November 19, 2020.

For more patient information about secondhand smoke and children, vaping, and other ENT-related conditions impacted by smoking and vaping, go to ENThealth.org.

Christopher Hartnick, MD, of MEEI; Jose Bonilla, MD, of Bloom Hospital, El Salvador; and Asitha Jayawardena, MD, of MEEI conducting laryngotracheal reconstruction.

Sustainable Surgical Outcomes in the Pediatric Airway: The Operation Airway Experience

Asitha Jayawardena, MD, MPH; Jose Bonilla, MD; Marcos Mirambeaux, MD; Evelyn Zablah, MA; Christopher Hartnick, MD, MS

As a surgeon there is nothing more gratifying than using your own skill set to perform complex airway reconstruction and allowing children to breathe, speak, and ultimately rediscover their livelihood again. At Operation Airway, however, the goal of the teaching surgeon is quite the opposite. By the end of the mission, or series of missions, the goal is ultimately to be able to participate solely as an observer, watching the local team navigate through complex decision-making and technically challenging cases. At the end of the mission, the less operating that is necessary for the teaching surgeon to do, the better.

This philosophy has guided Operation Airway's strategy over the past 10 years. A careful program of surgical teaching that relies on graduated autonomy and discipline-to-discipline teaching has allowed two countries to have "graduated" from the program into conducting pediatric airway surgeries in a safe, effective manner.

This thoughtful, surgical teaching program relies on a carefully vetted team of pediatric otolaryngologists, pediatric anesthesiologists, pediatric intensivists, speech-language pathologists, respiratory technicians, and nursing staff. Airway surgery is inherently a team sport, meaning that a supremely skilled surgeon still relies on high-quality intensive care, anesthesia, respiratory, and nursing teams to manage

the postoperative course of the airway reconstruction.

To that end, a multidisciplinary technology-based teaching module has been created and utilized to obtain optimal outcomes. Each teaching module is available in multiple languages and accessible at all times via QR codes. The QR codes themselves are placed at the patient's bedside so any practitioner with specific questions can have them answered in real time.

Sustainable surgical approaches are the focus of these missions, with airway tools being constructed out of local resources (e.g., tube within a tube, needle cricothyrotomy kits). In fact, we have learned from our colleagues in other countries and use a portable, handheld suction for patient/family use in the postsurgical airway. This allows the local practitioners to feel that they can conduct safe surgeries even after the teaching team leaves.

Measuring long-term surgical outcomes is imperative in mission trips, and too many teams fail to do this adequately. We now utilize a homegrown electronic medical record system that allows, for example, operative reports and follow-ups to be directly uploaded into the system. This facilitates multidisciplinary communication and allows prompt end-of-mission summaries to be created for the local teams. Lastly, this facilitates scrutiny of our team's postsurgical outcomes.

Thus far, we have conducted 14 missions in Ecuador, El Salvador, and the Dominican Republic.[1] A total of 135 procedures have been performed on 90 patients. Thirty-six of those procedures were laryngotracheal reconstruction. A decannulation rate of 82% has been achieved, and two countries—Ecuador and the Dominican Republic—have graduated from the program. Achieving specific graduation criteria suggests that a country is now able to perform complex pediatric airway reconstruction (laryngotracheal reconstruction with rib graft, tracheal resection, slide tracheoplasty, etc.) autonomously.

Although this is a surgery-centered effort, our interventions are not limited to surgery alone. A retrospective review of our data revealed that the pediatric intensive care unit (ICU) in one of our hospitals had a mortality of 27% for all admitted non-airway patients. Further review found that the team needed education in appropriate securement of endotracheal tubes and management of a cuffed endotracheal tube. A multidisciplinary education effort reduced accidental extubation rates in the ICU by nearly 50% and dropped mortality by 4%. The cost-effective intervention was only $1.32 per patient and therefore about $30.70 per life saved. This intervention would only be possible with thorough review of the reported outcomes, philanthropic donations (Thank you, Benjamin Harry Peikin Foundation!), curiosity of the investigators, and an enormous effort by the local teams to improve their own outcomes.

Marcus Mirambeaux, MD, of the Dominican Republic and Christopher Hartnick, MD, of MEEI conducting a slide tracheoplasty.

Local support is imperative and the crux of Operation Airway's success. Local surgical leaders help our team navigate the complexity of an international healthcare system and facilitate the growth of national airway programs within each country. Furthermore, the training of local surgical trainees is an important aspect of each mission. Residents of all levels participate in experience-appropriate aspects of the surgeries. Surgical leaders of graduated programs often teach in other countries and help share local pearls and pitfalls to facilitate success.

The surgical learning that occurs on these trips is by no means a unilateral effort. We learn as much from local surgeons in low-resourced settings about management using limited resources as they learn from us regarding surgical techniques.

One of the most rewarding aspects of participating on these trips, however, is not the surgical experience. Rather, it's handing the reigns over to local, junior surgeons and observing as they complete a complex pediatric airway operation, needing you for only the celebratory high five at the end of the case. The friendships, mentorships, and partnerships are priceless.

More information regarding our team and our efforts can be found here: **https://www.operationairway.com/** ■

This topic was presented as part of the International Symposium of the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience.

References:

1. Jayawardena ADL, Ghersin ZJ, Mirambeaux M, et al. A sustainable and scalable multidisciplinary airway teaching mission: the Operation Airway 10-year experience. *Otolaryngol Head Neck Surg*. 2020. doi: 10.1177/0194599820935042

OUT OF COMMITTEE: OUTCOMES RESEARCH AND EVIDENCE-BASED MEDICINE

Tonsillectomy Versus Tonsillotomy for Pediatric Sleep-Disordered Breathing

Erin Kirkham, MD, MPH; Nikhila P. Raol, MD, MPH; Joshua R. Bedwell, MD; Derek J. Lam, MD MPH

Tonsil surgery has been performed for millennia by techniques that have ranged from fingernail dissection in the first century AD to modern electrocautery today. Tonsillectomy refers to the complete removal of the encapsulated tonsil from the pharyngeal muscular wall. Tonsillectomy (with or without adenoidectomy) is the first-line treatment for sleep-disordered breathing (SDB) in children, and over 300,000 pediatric tonsillectomies are performed in the United States annually.[1] Tonsillectomy results in expected postoperative pain with decreased oral intake. The procedure also carries risks of more serious complications that can include dehydration, hemorrhage, severe airway compromise, and even death.

Tonsillotomy (also referred to as intracapsular or partial tonsillectomy) is a method of tonsillar debulking that spares the tonsillar capsule and avoids exposure of the pharyngeal musculature. As the most common indication for tonsil surgery in children has evolved from recurrent infection to SDB, the goal of surgery has changed from removal of a nidus for infection to the relief of upper airway obstruction. Proponents of tonsillotomy argue that while tonsillectomy may be necessary to prevent infection, tonsillotomy may suffice to reduce obstruction and may result in less pain and lower rates of bleeding. Critics of tonsillotomy cite unacceptable rates of regrowth, increased surgical time and cost, and doubt about clinically significant differences in pain and complications compared with tonsillectomy. Nonetheless, tonsillotomy has gained popularity in recent years with an associated increase in studies that compare intracapsular and total tonsillectomy with respect to a range of outcomes.

In this month's *Bulletin*, we highlight a Cochrane review published by Blackshaw and colleagues that explores differences in outcomes between the techniques.[2] The authors included 22 randomized controlled trials of tonsillectomy versus tonsillotomy (with or without adenoidectomy) for treatment of SDB in children aged two to 16 years. The authors did not exclude any studies based on the specific technique, such as electrocautery, cold steel, and coblation, used to perform either procedure.

Treatment of SDB

There were no significant short-term (zero to six months) or long-term (12-24 months) differences between the procedures with respect to improvement in disease-specific quality of life, SDB symptoms, behavior, or polysomnography measures.

Surgical time

Surgical time was 2.5 minutes shorter in favor of tonsillectomy.

Pain and recovery time

There was no evidence for a difference in pain scores at 24 hours, two to three days, or four to seven days postoperatively. Patients who underwent tonsillotomy were able to discontinue analgesics on average 2.8 days earlier, return to a normal diet on average three days earlier, and return to normal activity on average four days earlier than those who underwent tonsillectomy.

Short-term complications

Though there were no clinically meaningful differences in the volume of intraoperative blood loss, the authors found moderate evidence that, compared with tonsillotomy, tonsillectomy had 1.75 times the risk of subsequent medical intervention for dehydration, infection, or hemorrhage within seven days of initial surgery. However, the risk was low in both groups at 4.9% for tonsillectomy versus 2.6% for tonsillotomy.

Long-term complications

Children who underwent tonsillotomy did not have an increased risk of throat infection, recurrence of SDB due to tonsillar regrowth, or need for reoperation at six, 12, or 24 months of follow-up.

Limitations

Due to the heterogeneity of effect size estimates, wide confidence intervals, and high risk of various types of bias in the included studies, the conclusions drawn for the majority of the reported outcomes were of very low certainty. The exceptions to this were the need for medical intervention within the first week and return to normal function, where evidence was of moderate certainty. Variation in instrumentation and cost was not considered; however, a 2018 cost-effectiveness analysis found that monopolar tonsillectomy was more cost-effective than microdebrider tonsillotomy.[3]

Furthermore, the review included only randomized controlled trials with limited duration of follow-up, which is not the best study design to capture rare or long-term events. Longitudinal cohort studies conducted in Scandinavia suggest that tonsillotomy results in reoperation specifically on the tonsils in 3.9% of children but reoperation for either tonsils, adenoids, or both in up to 9.4% of children within three years.[5] Overall, the risk of reoperation in the cohort was seven times higher for tonsillotomy than for tonsillectomy.[4] This is strongly age dependent, with the highest rates of reoperation in children less than four years of age.[5]

Implications for practice

There is low-quality, limited evidence that tonsillotomy is no less effective for treatment of pediatric SDB than tonsillectomy, at least in the short term. There is moderate-quality evidence that tonsillotomy may confer short-term benefit in reducing immediate postoperative complications and facilitating faster return to normal activity. However, the short-term benefits of tonsillotomy must be balanced with respect to cost and the long-term probability of tonsillar regrowth, SDB recurrence, and the need for reoperation. ■

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FROM THE EDUCATION COMMITTEES

Biologics in the Management of Chronic Rhinosinusitis with Nasal Polyposis

Alice Z. Maxfield, MD, and **Stacey T. Gray, MD,** For the Rhinology and Allergy Education Committee

Chronic rhinosinusitis (CRS) is a chronic inflammatory disease involving the sinonasal mucosa that can be classified into subtypes based on the presence or absence of nasal polyps. CRS with nasal polyps (CRSwNP) is a Type II mediated inflammatory process with elevated eosinophils and inflammatory cytokines, such as Interleukin (IL)-4, IL-5, and IL-13. Asthma, which shares similar immunologic features, frequently accompanies CRSwNP as a comorbid condition in up to 48% of patients. Aspirin-exacerbated respiratory disease (AERD) is a subtype of CRSwNP that presents with a triad of bronchial asthma, nasal polyposis, and respiratory reaction to aspirin and nonsteroidal anti-inflammatory drugs. Better understanding of the pathophysiology of CRSwNP has led to the use of novel therapies that target the inflammatory pathway. Most recently biologics have emerged as an option for treatment for patients with severe and recalcitrant disease.

Studies have shown that CRSwNP has a significant negative impact on patient quality of life, affecting work productivity and sleep, and leading to social and emotional consequences. There is a 4.2% prevalence of CRSwNP in the United States, and of these, 16% of patients have AERD. Traditional treatment of CRSwNP includes a combination of therapies that decrease inflammation of the sinonasal mucosa and thereby minimize patient symptoms. Treatment for CRSwNP typically starts with standard medical therapy, including antibiotics, oral corticosteroids, topical nasal steroids, and nasal irrigations. Ultimately, endoscopic sinus surgery can be considered for patients who fail to respond to appropriate medical treatment. Unfortunately some patients with CRSwNP, especially patients with AERD, are susceptible to more severe disease with early recurrence of nasal polyps after surgery, systemic corticosteroid dependence, and poor asthma control despite appropriate medical and surgical intervention. Thus, targeted therapies that control the underlying pathophysiology provide another option for management of this chronic disease.

Biologic drugs target specific substances in the immune system that cause inflammation. Designed as monoclonal antibodies that are directed against different inflammatory mediators: omalizumab (IgE), mepolizumab (IL-5), reslizumab (IL-5), and dupilumab (IL-4, IL-13) have all been utilized. Previous work has shown successful management of persistent asthma, eczema, and chronic idiopathic urticaria with these biologics. More recently biologics have been applied to the treatment of CRSwNP. Dupilumab was originally approved in 2017 for uncontrolled eczema and eosinophilic asthma or those dependent on oral corticosteroids. In 2019, the FDA approved dupilumab specifically for the treatment of CRSwNP inadequately controlled with standard therapy.

Several clinical trials have studied the benefits of biologics in the management of CRSwNP. Mepolizumab has been found to reduce nasal polyp size in those with severe eosinophilic nasal polyposis. In recent randomized controlled trials, patients receiving dupilumab compared to a placebo group had significant improvement in nasal congestion and obstruction, sense of smell, and overall decreased need for oral corticosteroids and surgery. In those study participants who also had asthma, lung function improved and asthma was better controlled. There were also reductions in nasal polyp size and improvements seen on imaging studies. Patients experienced improvement of symptoms as early as four weeks into treatment and continued to experience greater improvement than the placebo group for up to one year. Although generally well tolerated, the most common reported adverse events were nasopharyngitis, injection site reaction, epistaxis, and headache. One of the biggest concerns regarding the use of biologics is the cost of therapy. A conservative yearly cost of $31,000 for dupilumab was estimated for the treatment of asthma. Additionally, from a cost utility analysis perspective, primary and revision endoscopic sinus surgery was found to be more cost-effective compared to dupilumab for CRSwNP patients. More studies are needed to assess the long-term results of biologic therapy in the treatment of CRSwNP, and the development of treatment algorithms will help inform the appropriate usage in a safe and cost-effective manner.

Current medical and surgical treatments of CRSwNP have limitations, especially in those patients with severe, recalcitrant disease who require frequent systemic corticosteroids or multiple revision surgeries. Biologics offer the ability to target the underlying immunologic process that drives the Type II mediated disease progression. CRSwNP significantly impacts quality of life but also has a substantial impact on healthcare cost and resource utilization; thus, biologics, when utilized appropriately, offer a new and innovative option for patients with poorly controlled disease. ■

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

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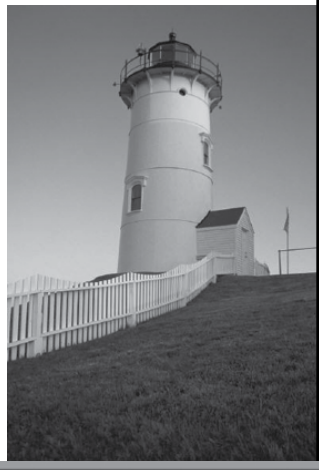

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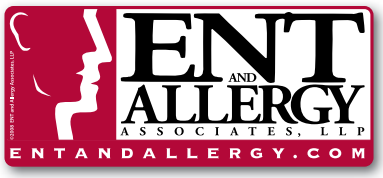

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