

bulletin



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

APRIL 2021

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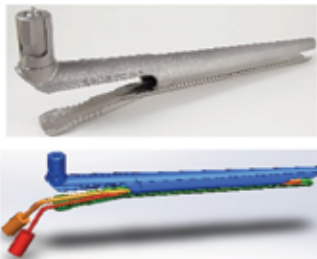
TWO NEW ZEITELS LARYNGOSCOPES

The 1st Novel Laryngeal Surgical Speculum Design Developments in Decades

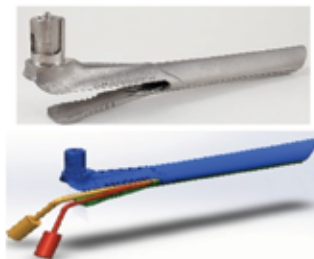
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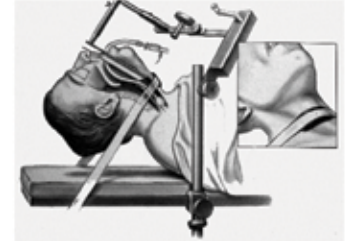
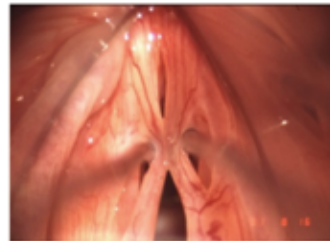
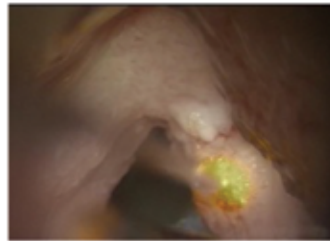
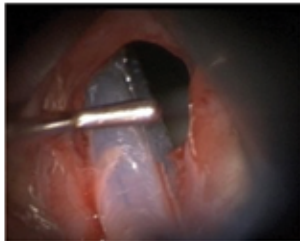
UNIVERSAL MODULAR
SLIM GLOTTISCOPE



(ORIGINAL) UNIVERSAL
MODULAR GLOTTISCOPE



LARYNGOSCOPIC
SUSPENSION GALLOWES



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bulletin features

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The leading edge

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Why the Power of Our Voice Matters

“The human voice is the most perfect instrument of all.”

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As otolaryngologists, we know better than anyone how critically important the human voice is.

Patients with a wide range of throat ailments—from throat cancer to a crushed larynx—expect us to preserve their voices. We approach the vocal tract with extreme caution and delicate dexterity to ensure that patients are able to communicate verbally following surgery and other interventions.

And as World Voice Day approaches, our profession comes together to encourage our patients to assess their vocal health and take steps to take care of their voices.

But have you ever noticed that we sometimes fail to recognize the power of our own voices? Do we find our voices when we see or hear something that is not aligned with our core purpose and guiding principles? Do we speak up when a member of our community is not treated equitably? Are we using our voices to advocate for our patients and our practices? Are we asking questions at the conclusion of an education session when the learning objectives are not clear?

There are times when we know there is more to be said and heard.

As they say, the silence can be deafening.

Now, more than ever, we encourage our members to speak up and be heard. As we update our strategic plan, this is a critical time for our future. The more ideas we hear and different perspectives we consider, the greater the chances we will realize our vision together.

Actor Maggie Smith once said, “Speak your mind, even if your voice shakes.” I challenge you to be bold, to find your voice, and to use it for the betterment of our organization and society at large. We are all experts in something, and we are stronger when you share your knowledge, ideas, and perspectives.

In a large organization such as ours, there are times when you might feel your voice is not heard. I urge you to keep trying, as our goal is to ensure that not only is your voice heard, but also that your voice speaks for the future of the American Academy of Otolaryngology–Head and Neck Surgery.

There are many avenues where you can share, including committees, meetings, conferences, and elections. In fact, the election for positions on the Academy’s Board of Directors is right around the corner. I encourage you to read the candidates’ statements, starting on page 24, then cast your vote when the election opens on May 3. Let your voice be heard as we select our future leaders.

Thank you for your voice and for your contributions to our collective future as an Academy. ■



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

“ I challenge you to be bold, to find your voice, and to use it for the betterment of our organization and society at large.

”

ASCENT

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Focusing on Our Strategy for Today Outlines Our Plans for the Future

As we enter the second quarter of 2021, it becomes clear that really nothing will be clear in healthcare for the rest of this year on many fronts. Both government and private payers continue to mandate additional requirements related to quality and payment. The COVID-19 pandemic has unleashed a flurry of scope of practice expansions at the state and national level, including the Veterans Administration hospitals. The short-term gains touted as a “great victory” for limiting surgical cuts only succeeded in delaying them and, as things stand now, putting otolaryngologists in a worse position than we would have been without the Consolidated Appropriations Act, 2021. We are now facing resumption of the 2% sequestration through the end of 2021 and an additional 4% sequestration starting in January 2022 courtesy of the recently passed \$1.9 trillion COVID-19 relief bill. There is also concern that inpatient E/M CPT codes will be increased in the proposed rule this year, which will further reduce the value of surgical procedures. This will also include the loss of the “G” code that was to be used as an add-on for complex E/M services and expected to be utilized for at least 50% of otolaryngology E/M services.

The recent AAO-HNS/F strategic planning process identified a high priority need for expanded “business of medicine” services within the Academy. We will be further developing our advocacy staff with two new directors, including one to specifically deal with private payer and health policy issues. As the volume and complexity of these problems grow, this will be a significant addition to services we can provide for our members. This year, just as in the past several years, it will be critical to identify the appropriate partners for each of the issues facing us. They will not necessarily be the same ones for every issue as there is considerable disagreement within the house of medicine on many of them. One of the great opportunities we hope to take advantage of is the willingness of many of the large private payers to listen to suggestions that would standardize indications, coverage decisions, and documentation requirements. We are currently working with the American Rhinologic Society on standardizing imaging requirements related to chronic rhinosinusitis for presentation to multiple insurance companies. If

this is successful, we can expand to other areas in the specialty. This would save the insurers, patients, and physicians both time and resources and result in an improvement in the “wellness factor” in dealing with so many disparate rules.

The emergence from the COVID-19 cloud will certainly bring about a number of changes in the way otolaryngologists practice, both in the clinic setting and the operating room. The *Bulletin* will have regular features on the many aspects of the “new normal” as it emerges. One of the first areas we will be exploring is what PPE will look like in our offices and surgery in the post-COVID era. The Future of Otolaryngology Task Force and the Patient Safety and Quality Improvement Committee will lead that effort, which will be followed with a special presentation at the Annual Meeting in Los Angeles, California. What will the telehealth world look like for otolaryngologists in practice as well as in teaching situations? Will the expansion of allied health provider’s privileges return to pre-pandemic levels or continue to expand? How will the over-the-counter availability of hearing aids change the hearing healthcare landscape? These are but a few of the many questions that will need to be answered sooner than later.

In addition to allocating more resources to address the advocacy issues listed above, we are also expanding our offerings related to “Wellness and Resiliency” as the problem continues to surge through and following the pandemic. The additional stresses that will result from system reform will be additive. The strategic planning process also identified this area as a high priority, and we will be adding a new position that will focus on wellness initiatives for our members.

The key to success over the next several years will be greatly impacted by our ability to execute the Five Fs. We must be **familiar** with the issues affecting us, **find** the ones where we can make a difference and develop a plan, have **flexibility** in how we tackle the problem, work with **friends** who have like issues, and **finish** strong with data-driven solutions. I do know for sure we will not be successful without the help of all our members and hope that if you are called upon to help, you will make yourself available. ■



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

“We must be **familiar** with the issues affecting us, **find** the ones where we can make a difference and develop a plan, have **flexibility** in how we tackle the problem, work with **friends** who have like issues, and **finish** strong with data-driven solutions.”

”

■ milestone moments



1903

Transactions from the Annual Meetings in 1896 and 1897 were collected, preserved, and disseminated. Beginning in 1903, these papers were released in a bound, hardcover collection as *The Transactions of the American Academy of Ophthalmology and Oto-Laryngology*.

1975

Transactions was separated into two publications, one for ophthalmology and one for otolaryngology.

1977

The otolaryngology version was retitled to *Otolaryngology*.

1981

The journal's name was changed to its present title, *Otolaryngology-Head and Neck Surgery*, concurrent with the formal name change of the Academy.



Looking Ahead: May Is Better Hearing and Speech Month

ENThealth.org offers information for your patients

Hearing Loss with the Use of Protective Face Masks offers tips to help maximize the ability to hear when someone is wearing a face mask or covering.

https://www.enthealth.org/be_ent_smart/hearing-loss-with-the-use-of-protective-face-masks/

How Can I Lessen the Impact of Tinnitus? offers tips for reducing the impact of tinnitus and answers some frequently asked questions.

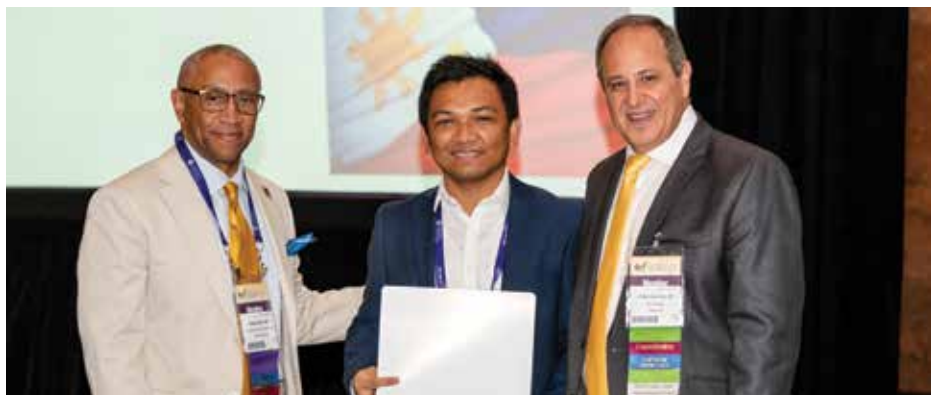
https://www.enthealth.org/be_ent_smart/how-can-i-lessen-the-impact-of-tinnitus/

Speech and Language Development is gleaned from the AAO-HNSF Clinical Practice Guideline (update): Otitis Media with Effusion, which offers patient friendly information for caregivers when Otitis Media with Effusion affects speech and language development.

https://www.enthealth.org/be_ent_smart/speech-and-language-development/

For more patient information, search the **ENThealth.org** library of content of Conditions and Treatments and Be ENT Smart articles by using keyword searches “hearing” and “speech.”

ENThealth.org is dedicated to helping patients. The content is developed from a team of AAO-HNS members, and information is delivered via peer-reviewed articles, interactive features, and video content featuring physicians. Learn more about the site and our contributors at <https://www.enthealth.org/about-us/>. ■



2021 International Visiting Scholarship

Are you an international otolaryngologist-head and neck surgeon, less than 40 years old *or* within the first eight years of professional practice after residency or fellowship training, and in a junior full-time teaching position? You may be eligible for a Virtual International Visiting Scholarship or International Visiting

Scholarship (dependent on ability to obtain in-person observership).

The application deadline is May 1. Visit www.entnet.org/IVS or contact international@entnet.org for more information. Applications and supporting information must be submitted as a PDF to international@entnet.org. ■



WIO Day 2021 Celebrations

WIO Day was held on March 8 in conjunction with International Women's Day, which is a global day celebrating the social, economic, cultural, and political achievements of women. Here are a few ways the occasion was commemorated in 2021. For more social media activity, search #WomenInOtolaryngology. ■



The women in otolaryngology at University Hospitals Cleveland Medical Center had a virtual happy hour with a discussion centered around the published paper, "Barriers Pushed Aside: Insights on Career and Family Success from Women Leaders in Academic Otolaryngology."¹

1. Meyer TK, Bergmark R, Zatz M, Sardesai MG, Litvack JR, Starks Acosta A. Barriers Pushed Aside: Insights on Career and Family Success from Women Leaders in Academic Otolaryngology. *Otolaryngol Head Neck Surg*. 2019 Aug;161(2):257-264.

Loma Linda University Ear, Nose, and Throat Surgery faculty, fellows, residents, medical students, and otolaryngology colleagues in the inland empire region held an outdoor screening of the history of WIO documentary, "Four Days in Boston," followed by discussion.



AAO-HNS Past President Sujana S. Chandrasekhar, MD, Sabina Omerhodzic, MD, and Ellie Morse, MD, (seated) celebrated at the Bronx VA Hospital by donating to the WIO Endowment, sporting their pins, and showing their strength!



HUMANITARIAN TRAVEL GRANT

Medical Mission in Phnom Phen, Cambodia

In January 2020, **Jonnae Y. Ostrom, MD**, and **Sarah R. Akkina, MD, MS**, traveled with a team of volunteers from Northwest Medical Volunteers and Face to Face to Phnom Phen, Cambodia, to provide care to patients with congenital, traumatic, and neoplastic face deformities. This mission has been ongoing since 2006 when it was started by Seattle, Washington, otolaryngologist **Craig S. Murakami, MD**, and Cambodian plastic surgeon Theavy Mok, MD. The focus of these humanitarian missions is to provide care in the form of microtia repair, cleft lip and palate repair,

complex facial reconstruction, and head and neck cancer surgeries that would otherwise not be available.

In addition to helping patients who would not have access to such procedures, volunteers work closely with local physicians and residents from the Cambodian medical schools. A significant goal of the mission trip is to provide lectures, conduct one-on-one teaching, and operate side by side with Cambodian medical students and physicians.

Patients come from all over Cambodia and sometimes wait for days to be

evaluated for a potential surgery.

The Soviet Friendship Hospital becomes their home while they wait for their operations and recover before starting the journey home. Historically the mission has been completed once per year, but the number of patients presenting for evaluation continues to rise. Northwest Medical Volunteers, therefore, hopes to increase the frequency of trips to Cambodia in the future to further offset the reconstructive needs of the Khmer people. ■

➔ **READ MORE ONLINE**
Longer article available

■ section spotlight



Expanding Resident Education through a Pandemic and Beyond

Chelsea S. Hamill, MD



I am serving as this year's Society of University Otolaryngologists Head & Neck Surgeons (SUO)

delegate for the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) Section for Residents and Fellows-in-Training. SUO has a yearly meeting combined with the Association of Academic Departments of Otolaryngology and the Otolaryngology Program Directors Organization, which was originally scheduled for this past November. However, due to the unprecedented year, online webinars were offered on a variety of topics throughout the year. This year's online platform has shown me the immense collaboration and effort that goes

into resident education. And the best part? It is available for *all*.

Although the pandemic challenged us in many ways, these webinars have shown that resident education is still a priority: from AAO-HNS bringing us new education platforms to the creation of multiple education consortiums. Researchers are investigating how residents are using these virtual learning opportunities during the pandemic and how they may incorporate these new formats into residency program curricula.

Not only have they been working hard for the current residents, they are also looking into the future. This was first introduced when discussing inclusion within otolaryngology, given that the specialty has one of the lowest percentages of women, Hispanic, and Black physicians among its members. Further discussions centered on

incorporating these concepts within our resident education, normalizing these conversations within the workforce to push these agendas forward, and changing the recruitment process to increase diversity within otolaryngology.

While we are consciously changing the demographics of our future colleagues, we are also doing so in this new era without Step 1 scores. There are so many things to consider when reading an application. Thus, scientific programs are emerging to ensure that our future colleagues' personalities are cohesive within our field and values allow them to be successful.

Although I've summarized many of the themes of this year's discussions, I hope you can all see that our future colleagues are in good hands and encourage you all to listen to the webinars that are found online at <https://suoaado.org/mpage/pastwebinars2020>. ■



OTO Journal

CALL FOR PAPERS

deadline for submissions
DECEMBER 20, 2021
11:59 PM (ET)

Otolaryngology–Head and Neck Surgery is Seeking Papers Relevant to

DIVERSITY, EQUITY, AND INCLUSION IN OTOLARYNGOLOGY-HEAD AND NECK SURGERY

for a Themed Issue to be Published in Summer 2022

Submit papers for the themed issue at
www.editorialmanager.com/otohns

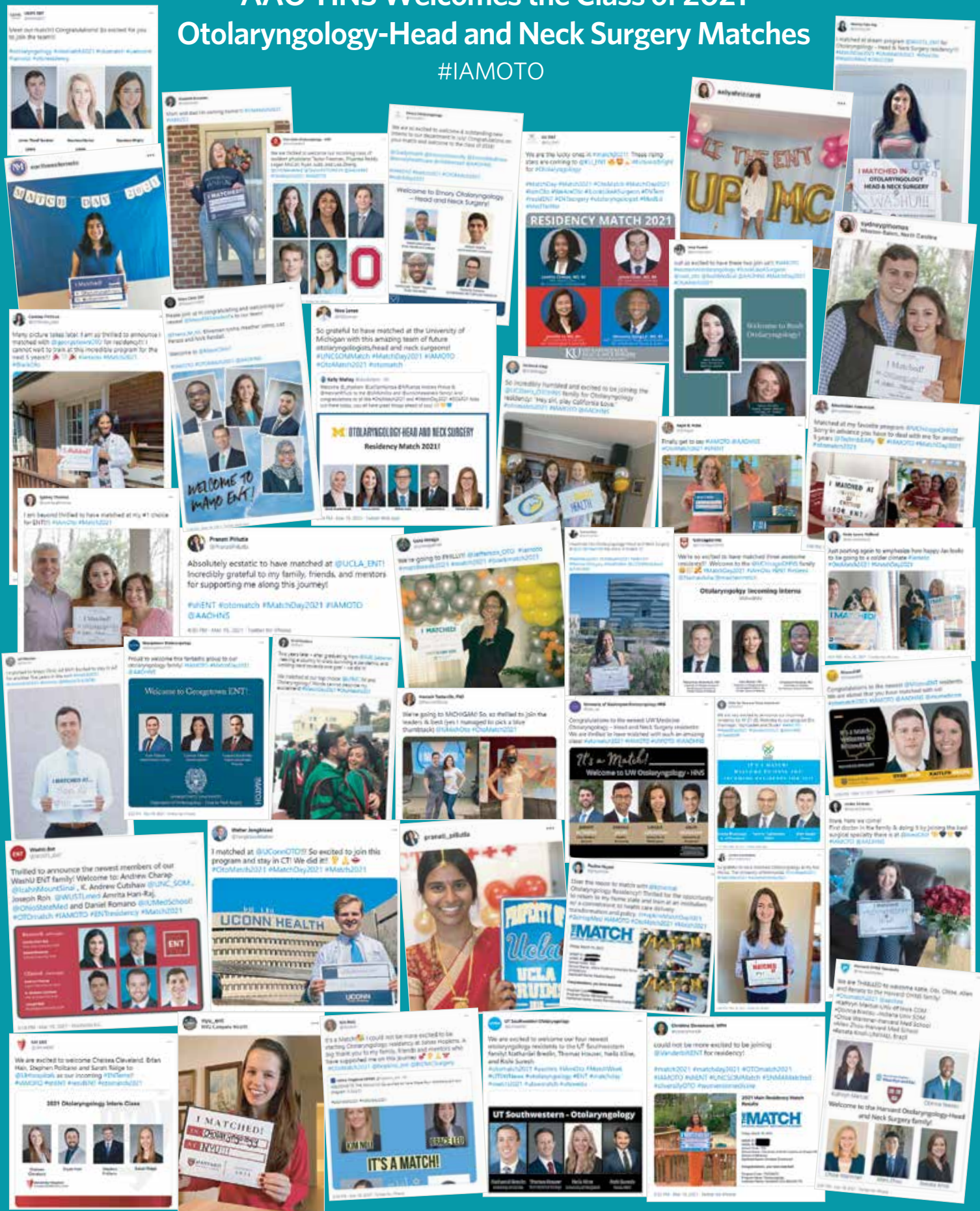


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If you have any questions, please contact the Editorial Office at otomanager@entnet.org.



**AAO-HNS Welcomes the Class of 2021
Otolaryngology-Head and Neck Surgery Matches**
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Visit www.entnet.org/otomatch to see a compilation of the Match Day activity shared on Facebook, Twitter, and Instagram.






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Worst Case Scenarios: Managing OTO Emergencies in Practice Simulation Workshop

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www.entannualmeeting.org

pearls from your **peers:** Dermal Filler Complications



INTERVIEWEE

Theda C. Kontis, MD

*Double Board-Certified Facial Plastic Surgeon, Baltimore, Maryland
Clinical Associate Professor, The Johns Hopkins Hospital, Baltimore, Maryland*

INTERVIEWER

G. Nina Lu, MD

Facial Plastic and Reconstructive Surgeon, University of Washington, Seattle, Washington

I'm **Nina Lu, MD**, a facial plastic and reconstructive surgeon at the University of Washington. I'm joined by **Theda C. Kontis, MD**, a double board-certified facial plastic surgeon practicing in Baltimore, Maryland, and clinical associate professor at The Johns Hopkins Hospital.

Dr. Lu: There has been quite the media buzz around dermal fillers and the COVID-19 vaccine. The U.S. Food and Drug Administration reported a total of three patients with facial swelling related to dermal fillers in the Moderna COVID-19 vaccine trial. Although this topic has garnered recent media attention, delayed swelling with dermal fillers is a rare but previously described event seen with vaccinations, viral infections, and allergic reactions. What do you recommend patients do with dermal fillers and vaccinations?

Dr. Kontis: I have not changed my practice at all, and I recommend all patients get

vaccinated as they are able. Currently, there isn't enough data to conclude a definitive timeline or need for delay between dermal filler and vaccinations. Delayed swelling is a very rare complication, and the Moderna study did not detail the type of hyaluronic acid filler used or the total number of patients in the trial who received dermal filler. The symptoms resolve easily with minimal treatment and no long-term side effects. I inform my patients of the details of the trial, that the risk is very low, and have them contact me if they experience any issues. To date there have been about 23 million COVID-19 vaccines given,* and we are not hearing of increased incidences of facial swelling. In my practice many of my filler patients have had the vaccine and have not experienced any filler complications.

Dr. Lu: If delayed facial swelling does occur, what is your typical treatment regimen?

Dr. Kontis: I examine the patient, and if it is just soft tissue edema, I start them on an oral antihistamine or Medrol Dosepak depending on the severity. If the filler is

very firm on palpation, I use Clarithromycin for three to four weeks. In recalcitrant cases I may consider an intradermal steroid injection, with or without 5-fluorouracil. Swelling typically resolves over the course of days to weeks.

Dr. Lu: The most devastating complication of dermal fillers is vascular occlusion. Luckily, this is very rare and avoidable by experienced injectors such as yourself. In the rare event that it does occur, what treatment regimen do you recommend?

Dr. Kontis: Recognition during the injection is the most important step. Skin blanching and pain are early warning signs, so stop injecting right away. I immediately place warm compresses and massage the area. If these maneuvers do not improve the blanched area, flood the pale area with hyaluronidase, apply topical nitro paste, and administer ASA 325. Most importantly, see the patient daily. Hyperbaric oxygen can be used for severe cases. ■

*This data is as of February 10, 2021, the date the article was submitted for publication.

Spotlight: Humanitarian Efforts

Miriam I. Redleaf, MD



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

I am an otologist/neurotologist and former tenured professor at the University of Illinois. Now, I am relocating to be in otology/neurotology and neurosurgery at the University of New Mexico.

What humanitarian organizations are you involved with, and describe what these programs do?

Our four adopted Ethiopian children are in their thirties now, and we have maintained close ties to the country. Since 2012 I have been discovering the infrastructure from which I and others developed education programs in Ethiopia through our charity called the Ethio-American Hearing Project. Some of the programs we provide include:

- Cued speech education in deaf schools
- Audiology training and development of audiology testing and treatment sites with the Eduplex Training Institute
- Otologic surgical training with six surgical (mostly university) sites

- Development of cochlear implantation in partnership with MED-EL
- Annual International Ethiopian Otology Conference (2020 canceled due to the COVID-19 pandemic)
- Parkinson's boxing program

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

I believe my work is worthwhile because we have trained five otologists in a country where there had only been one. Two more people are in training now, and two more are on deck to start. Furthermore, we trained 29 audiology technicians in a country where there were no audiologists and

only one hearing aid specialist. And we have been able to create a cochlear implant program using only Ethiopian nationals for the work in a country with no audiologists and no otologists.

My motivation for my work is fairness. I think it's only fair to share our education and get these Ethiopian colleagues on their feet.

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

My advice to other surgeons would be to put your ego aside and your hopes of operating without electronic medical record hassles and the elaborate obstacles in the United States—try to make the actual place you go to better. Of course we would all love to fly into a country and do 40 stapedectomies and then fly home knowing we helped 40 people hear better. But I strongly feel we have more of a duty to help the surgeons there do the 40 stapedectomies. A corollary to that principle would be that it's probably best to always go to the same country. ■



World Voice Day April 16, 2021: **ONE WORLD, MANY VOICES**

Sid Khosla, MD,
Voice Committee member



The theme for this year's World Voice Day (WVD) is "One World, Many Voices." Given the many interpretations of the theme, our committee thought it was important to gather the thoughts of "many voices." As you will see, the responses were as varied and beautiful as to be expected.

My own interpretation is as follows: One of the reasons I became a physician was to listen to people's stories, not the everyday conversations, but the more intimate details often discussed in the patient-physician relationship. I have come to think of these details and stories as the inner voice, a collective representation of what the person has experienced, who they are, and who they want to be. As a laryngologist, I previously focused on the external voice, assuming that a patient's inner voice has been established long before they met me. However, some of my patients have taught me otherwise, that changing the external voice can also influence the inner. I have found this to be especially true in my patients who cannot speak after laryngeal trauma. Because they have difficulty communicating, they often give up trying to express their opinions. They withdraw and the inner voice becomes faint and fluid. After reconstruction, I see their personality change. Their inner voice blossoms as they learn to speak up. I am lucky enough to participate in their beautiful transformations. However, this is not true just for out aphonic

patients. As otolaryngologists, speech language pathologists, or other voice professionals, we often see the inner voice change as the outer one becomes clearer. When I think of the theme of this year's WVD, it reminds me of our role as voice professionals and as citizens to encourage the expression of each person's individual voice.

I have reflected upon the 2021 WVD theme since it was first chosen in fall of 2020, a year which is irrevocably linked to the coronavirus pandemic, social unrest, and political discord.

I like the theme; it feels good to say it. I do have this tendency sometimes to think a lot about things, really a lot, and this theme became one of those things.

The words "One World" strike me as having multiple interpretations. One is a literal sense of a single planet Earth. A more philosophical sense invokes images of solidarity and unity of purpose, or less favorably, images of toddlers or, sadly, adults screaming "mine, mine" and fighting over that one world.

The words "Many Voices" also bring to mind multiple images. There are the voices of a well-conducted ensemble, weaving together into harmonious music. The contrasting image of people shouting with a goal of drowning out other voices also comes to mind; discordant tones lacking synchrony or harmony.

So "One World, Many Voices" is a wonderful theme, but I guess open to interpretation. I, of course, kept thinking about it, and it occurred to me that there are both expressive and receptive elements to actual communication. Right? Listening, really listening, to other voices is an essential part of that calculus.

Perhaps a good interpretation of this theme is actually: One World, Many Conversations? Yeah?

I kind of like that. Let's think about that for a while.

Norman D. Hogikyan, MD

Ann Arbor, Michigan

In *The Spell of the Sensuous*, a magnificent reflection on the disconnect of modern bodies from the natural world, ecologist and philosopher David Abram dedicates a chapter to air. As Abram explains, air is held sacred in the Navajo culture: the air entering and departing the individual through respiratory organs ultimately connect us to the surrounding winds of nature and the greater forces of the universe. Through the ritual power of speech and song and the air exchanges produced, the Navajo can alter events in the enveloping cosmos and impart their well-being in the surrounding spirit of the land. The palpable medium of the air is both spiritually and materially connecting us to each other and to the world.

Similarly, the absence of vowels in the traditional Hebrew aleph-beth may have been intended to avoid making visible the likeness of the divine through the representation of “sounded breaths.” The Hebrew texts need to be “inspired” by the reader’s breath to become alive and link the divine word with the world.

Contemplating this theme of “One World, Many Voices,” I cannot help but think about the powerful tangible, yet invisible, medium of air connecting our manifold voices to each other and to the world. As we are emerging from the slumber of these pandemic months, air has become both a dangerously infectious substance that separates us from each other and that which we long to exchange outside lockdown restrictions with each other and the world through our uncovered voices.



Anaïs Rameau, MD, MPhil

New York, New York

Perhaps one of the most important facts revealed by this pandemic is that we all live as parts of the same whole on this beautiful planet, regardless of religion, language, race, and color. On these hard days, we all hear and understand the feelings and voices of other people living in different parts of the world since we all have become equal in the face of this global threat. This is exactly why we need



to pay more attention to each other’s voices and try to hear and understand each other better now. Our voices will be the most important tool in removing the barriers among us and bringing us all together despite our cultural, social, and economic differences. We have one world, and yet, we have many voices to sound, hear in order to make it a better place for living.

Hakan Birkent, MD

Istanbul, Turkey

In Turkey we celebrate World Voice Day by emphasizing the importance and beauty of the voice. Although we will carry out this year’s activities in virtual environments, we aim to celebrate the World Voice Day activities next year simultaneously with the Voice Istanbul Meeting. May your voice always be good. I hope that the coming days will be better, and I wish everybody a happy World Voice Day with warm feelings from Turkey.



Gustavo P. Korn, MD

São Paulo, Brazil

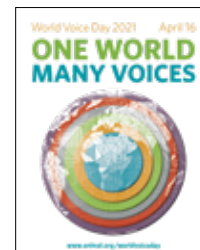
On April 16, Brazil will celebrate the 22nd edition of the National Voice Campaign. The National Voice Campaign, a joint effort by the Brazilian Academy of Laryngology and Voice and the Brazilian Association of Otolaryngology-Head and Neck Surgery, lasts for one week including April 16. Since 2003 (after its founding in 1999), it has gained international recognition in the form of World Voice Day and currently, more than 100 countries have adopted the same date and symbol for World Voice Day. Since then, many services nationwide have voluntarily participated in editions, offering free care to citizens during Voice Week, focusing on early diagnosis of laryngeal cancer and detection of alterations, and speeding up the therapeutic approach.

Throughout these two decades, we have remained focused on the greater goal of the Voice Campaign, which uses guidance and awareness-raising activities to promote lasting awareness of voice care. Each year means another brick in the construction and



Download the World Voice Day 2021 Poster

Share the poster featured here with your patients and spread the word about the importance of a healthy voice. Visit www.entnet.org/worldvoiceday to print your 2021 poster and access other World Voice Day resources.



POWERED BY AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY

Voice-related Patient Information

Disorders that affect the ability to speak and swallow properly can have a tremendous impact on lives and livelihoods. ENT specialists treat sore throat, infections, gastroesophageal reflux disease (GERD), throat tumors, airway and vocal cord disorders, and more.

NEW! Understanding Your Voice Care Team
NEW! Benign Phonotraumatic Lesions
NEW! Laryngopharyngeal Reflux Management and Lifestyle Changes

For more patient information, go to ENThealth.org.

creation of this alert message—prevention and therapeutics. Besides voluntary collaboration of prominent national public figures and open presentations like beat box battles, from 2010 to 2018, an inflatable giant larynx structure was developed—in reality a giant mouth-pharynx-larynx model—that visitors can enter and learn about the anatomy of the throat and how the voice is produced. Over the years, thousands of people including children have visited our inflatable model. Information about voice care was also presented in media. ■

CLINICAL PRACTICE GUIDELINE

Opioid Prescribing for Analgesia After Common Otolaryngology Operations

Adapted from the April 2021 Supplement to *Otolaryngology–Head and Neck Surgery*. Read the clinical practice guideline (CPG) at otojournal.org.

Opioid use disorder (OUD), which includes misuse, abuse, and overdose of opioids, is an epidemic in the United States. According to data from the National Survey on Drug Use and Health, more than six million people ages 12 or older misuse prescription pain relievers every year in the United States.¹ Additionally, studies have shown that there is a significant risk of chronic opioid use even when used as short-term treatment for pain.²

“As otolaryngology-head and neck surgeons, we can help reduce the risk of OUD among our patients and their families. This CPG focuses on multimodal analgesia and judicious use of opioids for common otolaryngology procedures,” said **Samantha Anne, MD, MS**, Chair of the Guideline Development Group (GDG). **James "Whit" Mims, MD**, served as Assistant Chair, and **David E. Tunkel, MD**, and **Richard M. Rosenfeld, MD, MPH, MBA**, served as Methodologists.

The purpose of this specialty-specific guideline is to provide evidence-informed recommendations on postoperative management for pain in common otolaryngologic surgical procedures, with a focus on opioids.

In addition, it allows identification of quality improvement opportunities in postoperative pain management of common otolaryngologic surgical procedures. Employing the key action

statements from this CPG can help to reduce the variation in care across the specialty and improve postoperative pain control while reducing the risk of OUD.

“Many times opioids are prescribed in large quantities for procedures that are associated with mild to moderate pain, such as parathyroidectomy, thyroidectomy, and otologic surgeries. The number of opioids prescribed for these procedures can be reduced, especially if appropriate multimodal analgesia is used,” says Dr. Anne. “The guideline also emphasizes the importance of counseling patients and identifying patient- and procedure-related factors that can inform shared decision-making.”

The guideline addresses assessment of patients for OUD risk factors, counseling on pain expectations, and identifying factors that can impact pain duration and/or severity. It also discusses the use of multimodal analgesia as first-line treatment and responsible use of opioids. Lastly, safe disposal of unused opioids is discussed.

The guideline reviews the healthcare burden caused by OUD. It highlights research on opioid prescribing and misuse in the U.S. as well as the mortality attributed to opioid overdoses. Additionally, it presents data on overprescribing of opioids for postoperative pain and the diversion of unused opioid medication.

Guideline Key Action Statements (KASs)

KAS 1: Expected Pain (recommendation)

Prior to surgery, clinicians should advise patients and others involved in the postoperative care about the expected duration and severity of pain.

KAS 2: Modifying Factors (recommendation)

Prior to surgery, clinicians should gather information specific to the patient that modifies severity and/or duration of pain.

KAS 3A: Risk Factors for Opioid Use Disorder (strong recommendation)

Prior to surgery, clinicians should identify risk factors for OUD when analgesia using opioids is anticipated.

KAS 3B: Patients at Risk for Opioid Use Disorder (recommendation)

In patients at risk for OUD, clinicians should evaluate the need to modify the analgesia plan.

KAS 4: Shared Decision Making (recommendation)

Clinicians should promote shared decision making by informing patients of the benefits and risks of postoperative pain treatments that include nonopioid analgesics, opioid analgesics, and nonpharmacologic interventions.

KAS 5: Multimodal Therapy (recommendation)

Clinicians should develop a multimodal treatment plan for managing postoperative pain.

KAS 6: Nonopioid Analgesia (strong recommendation)

Clinicians should advocate for nonopioid medications as first-line management of pain after otolaryngologic surgery.

KAS 7: Opioid Prescribing (recommendation)

When treating postoperative pain with opioids, clinicians should limit therapy to the lowest effective dose and the shortest duration.

KAS 8A: Patient Feedback (recommendation)

Clinicians should instruct patients and caregivers how to communicate if pain is not controlled or if medication side effects occur.

KAS 8B: Stopping Pain Medications (recommendation)

Clinicians should educate patients to stop opioids when pain is controlled with nonopioids and stop all analgesics when pain has resolved.

KAS 9: Storage and Disposal of Opioids (strong recommendation)

Clinicians should recommend that patients (or their caregivers) store prescribed opioids securely and dispose of unused opioids through take-back programs or another accepted method.

KAS 10: Assessment of Pain Control with Opioids (recommendation)

Clinicians should inquire, within 30 days of surgery, whether the patient has stopped using opioids, has disposed of unused opioids, and was satisfied with the pain management plan.

The GDG included 16 members representing otolaryngology-head and neck surgery generalists and subspecialists, pain management, nursing, and consumers. The CPG is intended for otolaryngologists who perform surgery and clinicians who manage pain after surgical procedures. The target patients for the guideline are any patients treated for anticipated or reported pain within the first 30 days after undergoing common otolaryngologic procedures.

The Opioid Prescribing for Analgesia After Common Otolaryngology Operations

CPG was created using the methods listed in the AAO-HNSF “Clinical Practice Guideline Development Manual, Third Edition.” (<https://journals.sagepub.com/doi/full/10.1177/0194599812467004>)

The full guideline and other resources are available at www.entnet.org/opioidscpg and in *Otolaryngology–Head and Neck Surgery* as published at otojournal.org. ■

Guideline authors:

Samantha Anne, MD, MS (Chair); James W. Mims, MD (Assistant Chair); David E. Tunkel, MD (Methodologist); Richard M. Rosenfeld, MD, MPH, MBA (Methodologist); David S. Boisoeneau, MD; Michael J. Brenner, MD; John D. Cramer, MD; David Dickerson, MD; Sandra A. Finestone, PsyD; Adam J. Folbe, MD, MS; Deepa J. Galaiya, MD; Anna H. Messner, MD; Allison Paisley, CRNP; Ahmad R. Sedaghat, MD, PhD; Kerstin M. Stenson, MD; Angela K. Sturm, MD; Erin M. Lambie, MS, MPH; Nui Dhepyasuwan, MEd; and Taskin M. Monjur

Endorsed by:

American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), American Broncho-Esophagological Association (ABEA), American Head and Neck Society (AHNS), American Neurotology Society (ANS), American Otolological Society (AOS), American Rhinologic Society (ARS), American Society of Pediatric Otolaryngology (ASPO), Society of Otorhinolaryngology and Head-Neck Nurses (SOHN), The Triological Society

Disclaimer:

This guideline is not intended as the sole source of guidance in prescribing opioids and/or analgesics for common otolaryngologic procedures. Rather, it is designed to assist clinicians by providing an evidence-informed framework for decision-making strategies. The guideline is not intended to replace clinical judgment or establish a protocol for management for all individuals with pain after otolaryngologic surgery and may not provide the only appropriate approach to managing postoperative pain. As medical knowledge expands, and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions but are not absolute. Guidelines are not mandates. They do not and should not purport to be a legal standard of care. The responsible physician, in light of all circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNSF emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care, or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results.

References:

1. Center for Behavioral Health Statistics and Quality. Results from the 2014 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH1315DetTabs2014.pdf>. Published 2014. Accessed December 8, 2019.
2. Laval OD, Gold J, Murthy A, et al. Rate and Risk Factors Associated With Prolonged Opioid Use After Surgery: A Systematic Review and Meta-analysis. *JAMA Netw Open*. 2020;3(6):e207367.

CPG
Clinical Practice
Guidelines

Accompanying Resources:

- Plain Language Summary
- Executive Summary
- Slide deck
- Podcasts
- Patient handouts (in both English and Spanish)
- Official quick-reference pocket guide and app
- Video on safe storage and disposal of opioids

Access all of these resources and more at www.entnet.org/opioidscpg.

CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

FREQUENTLY ASKED QUESTIONS (FAQs) COMPARING NONOPIOID AND OPIOID MEDICATIONS

Frequently Asked Questions	Opioids	Nonsteroidal Antiinflammatory Drugs (NSAIDs)	Acetaminophen	Gabapentinoids
CAN I BE ADDICTED TO THIS?	Yes	No	No	Yes
WHEN ARE THEY USED—WHAT LEVEL OF PAIN?	Severe pain	Mild - Severe	Mild - Severe	Mild - Moderate
SHOULD I START WITH THIS MEDICATION?	No, use only if around-the-clock nonopioid medications are not enough.	Yes, you may start with this medication.	Yes, you may start with this medication.	No, only use if NSAIDs and/or acetaminophen is not enough.
IS THIS USED ALONE OR WITH OTHER MEDICATIONS?	Should be used in combination with other pain medications.	Can be used alone or in combination.	Can be used alone or in combination.	Should be used in combination with other pain medications.
CAN I STOP USING THIS MEDICATION AND HOW DO I STOP?	Sometimes this needs to be slowly stopped ("tapered") depending on how much you have taken. Talk about this with your health care provider.	This can be stopped at any time.	This can be stopped at any time.	Sometimes this needs to be slowly stopped ("tapered") depending on how much you have taken. Talk about this with your health care provider.

SOURCE: Anne SA, Mims JW, Tunkel DE, et al. Clinical practice guideline: opioid prescribing for analgesia after common otolaryngology operations. *Otolaryngol Head Neck Surg.* 2021;164(2_suppl):S1-S42.



www.entnet.org

ABOUT THE AAO-HNS/F

The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) represents approximately 12,000 specialists worldwide who treat the ear, nose, throat, and related structures of the head and neck. The AAO-HNS Foundation works to advance the art, science, and ethical practice of otolaryngology-head and neck surgery through education, research, and lifelong learning.

CLINICAL PRACTICE GUIDELINES

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Frequently Asked Questions	Opioids	Nonsteroidal Antiinflammatory Drugs (NSAIDs)	Acetaminophen	Gabapentinoids
WHAT ARE THE COMMON SIDE EFFECTS (REPORTED IN 3% OR MORE PATIENTS)?	Dizziness, nausea (very common), headache, drowsiness (feeling sleepy or tired), vomiting, dry mouth, itching, and constipation.	Upset stomach	Nausea, vomiting, headache, and insomnia (being unable to sleep).	Dizziness, drowsiness (feeling sleepy or tired), swelling in the hands and feet, weight gain, and blurred vision.
WHAT ARE THE SERIOUS RISKS AND WHAT IS THE RISK OF ADDICTION OR DEPENDENCE?	Respiratory depression (very slow breathing), misuse, abuse, addiction, overdose, and death from respiratory depression. Your risk of opioid abuse increases the longer you take the medication.	Stomach bleeding or ulcers, heart attack, kidney damage, and stroke. Celecoxib has a lower risk of stomach bleeding and/or ulcer formation over the short term.	Liver damage may occur at high doses (greater than 3,000 milligrams in 24 hours).	Suicidal thoughts, respiratory depression. Risks increase if you have kidney, liver, or heart disease or have suicidal thoughts.

Adapted from the American College of Surgeons' patient education brochure on *Safe and Effective Pain Control After Surgery*.¹²

SOURCE: Anne SA, Mims JW, Tunkel DE, et al. Clinical practice guideline: opioid prescribing for analgesia after common otolaryngology operations. *Otolaryngol Head Neck Surg.* 2021;164(2_suppl):S1-S42.



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CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

FREQUENTLY ASKED QUESTIONS (FAQs) ABOUT OPIOIDS

WHEN SHOULD I BEGIN TAKING MY OPIOID PAIN MEDICATION?	<p>Pain medication should be taken for severe pain as needed, but only if pain is not controlled with nonopioid medication (painkillers such as acetaminophen or ibuprofen).</p> <p>If you need opioids for severe pain, take them as prescribed on the medication's bottle.</p>
HOW MANY SHOULD I TAKE AT ANY GIVEN TIME?	<p>To figure out how many pills you should take, read the instructions on the medication's bottle or the instructions given to you by your health care provider.</p>
CAN I TAKE TYLENOL, ASPIRIN, OR ADVIL INSTEAD OF THIS MEDICATION OR WITH THIS MEDICATION?	<p>Probably yes, but you should check with your health care provider.</p> <p>Some prescribed pain medications combine acetaminophen with opioids. Taking additional acetaminophen with the prescribed combination pain medication could be unsafe.</p>
DO I NEED TO FINISH THE ENTIRE BOTTLE OF PILLS?	<p>No, pain medication should be taken when needed and pain medication must be stopped when pain is controlled.</p> <p>If your severe pain is under control, there is no need to finish the bottle.</p>
WHAT SHOULD I DO WITH THE PILLS THAT ARE LEFTOVER?	<p>Leftover pills should not be left in your home where someone else can take them.</p> <p>There are facilities that will take these leftover medications. Check with your health care provider.</p>
CAN I GIVE THESE PAIN MEDICATIONS TO FAMILY MEMBERS?	<p>No, medications should never be shared with a family member or anyone else.</p> <p>If you have any pills leftover, check with your health care provider or take them to a facility that will get rid of them safely.</p>

SOURCE: Anne SA, Mims JW, Tunkel DE, et al. Clinical practice guideline: opioid prescribing for analgesia after common otolaryngology operations. *Otolaryngol Head Neck Surg.* 2021;164(2_suppl):S1-S42.

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

Brief Summary of Prescribing Information

1 INDICATIONS AND USAGE

1.3 Chronic Rhinosinusitis with Nasal Polyposis

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

4 CONTRAINDICATIONS

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

5 WARNINGS AND PRECAUTIONS

5.1 Hypersensitivity

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

5.2 Conjunctivitis and Keratitis

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

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

5.3 Eosinophilic Conditions

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

5.5 Reduction of Corticosteroid Dosage

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

5.6 Patients with Comorbid Asthma

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

5.7 Parasitic (Helminth) Infections

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

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

6 ADVERSE REACTIONS

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

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

6.1 Clinical Trials Experience

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

Chronic Rhinosinusitis with Nasal Polyposis

A total of 722 adult subjects with chronic rhinosinusitis with nasal polyposis (CRSwNP) were evaluated in 2 randomized, placebo-controlled, multicenter trials of 24 to 52 weeks duration (CSNP Trials 1 and 2). The safety pool consisted of data from the first 24 weeks of treatment from both studies. In the safety pool, the proportion of subjects who discontinued treatment due to adverse events was 5% of the placebo group and 2% of the DUXIPENT 300 mg Q2W group.

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

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

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

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

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

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

Specific Adverse Reactions

Conjunctivitis

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

Eczema Herpeticum and Herpes Zoster

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

Hypersensitivity Reactions

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

Eosinophils

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

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

Cardiovascular (CV)

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

6.2 Immunogenicity

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

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

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

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

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

7 DRUG INTERACTIONS

7.1 Live Vaccines

Avoid use of live vaccines in patients treated with DUPIXENT.

7.2 Non-Live Vaccines

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

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Exposure Registry

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

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

Risk Summary

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

Data

Animal Data

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

8.2 Lactation

Risk Summary

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

8.4 Pediatric Use

CRSwNP

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

8.5 Geriatric Use

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

10 OVERDOSE

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

17 PATIENT COUNSELING INFORMATION

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

Pregnancy Registry

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

Administration Instructions

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

Hypersensitivity

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

Conjunctivitis and Keratitis

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

Eosinophilic Conditions

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

Reduction in Corticosteroid Dosage

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

Patients with Comorbid Asthma

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



CAST YOUR VOTE

Election opens May 3, 2021

How to Cast Your Vote

AAO-HNS has partnered with Election America to administer the 2021 election of candidates for leadership positions.

To ensure your election-specific broadcast email arrives safely in your inbox on May 3, simply add the following email address as an approved sender: **help+AAOHNS@election-america.com**. Those who have not provided an individual email address to the Academy will receive a personalized letter from Election America with information on how to access the ballot.

For technical support, please call 1-866-384-9978, or email **help+AAOHNS@election-america.com**. For ballot-related questions, call Membership at 703-836-4444, or email Lisa Holman at **elections@entnet.org**.

- Q:** What do you think is the most important issue that our Academy is currently facing?
A: What are the strengths of the Academy that will lead us forward in our specialty and how will you capitalize on those strengths?



Richard M. Rosenfeld, MD, MPH, MBA

The most important issue facing our Academy can be summed up in one word: relevance. There is intense competition among specialty, subspecialty, and other nonprofit associations for relevance and member dues, which can no longer be taken for granted as an automatic renewal. Our Academy's success rests with helping members succeed. Sustaining relevance means giving members the tools to be efficient, overcome challenges, and find joy in their work.

We can sustain relevance through value, diversity, and wellness. Value means a spectacular return on dues and volunteerism, with access to unique opportunities for personal and professional growth. Diversity and inclusivity are more essential than ever and can build upon existing committee efforts to address health disparities, improve workforce diversity, and promote equity and pipeline programs. Wellness initiatives, which at present focus largely on reducing stress and burnout, can be enhanced with lifestyle medicine, a new specialty that advocates for healthy eating, regular physical activity, restorative sleep, positive social connection, and avoiding risky substances.

The strengths of our Academy that will lead us forward are our diverse members, our incredible staff, and the synergy that flows from *specialty unity*. Now celebrating its 125th anniversary, the Academy is more unified than ever. As Past Chair of the ENT Political Action Committee (PAC), I coined the byline "10,000 ENTs, 1 PAC, 1 Voice"

to highlight the power of unity for political advocacy. Similarly, our unified voice in quality, education, research, communication, practice management, and international affairs transcends the efforts of smaller societies and empowers our members.

My qualifications to enhance relevance and unity stem from over three decades of Academy engagement, uniquely recognized with five Distinguished Service Awards. During this time, I attended every Annual Meeting and Leadership Forum, served on the Board of Directors for 10 years, and have generously supported the Hal Foster Endowment, Millennium Society, ENT PAC Leadership Club, Women in Otolaryngology (WIO) Endowment, Diversity Endowment, and many other causes.

I have seen firsthand the power of specialty unity in my roles as Journal Editor, Senior Advisor for Quality and Guidelines, and Chair of the Research Committee (now CORE), Guidelines Task Force (GTF), Science and Education Council (SEC), Cochrane Scholars Program, and the Subspecialty Advisory Council (SSAC). My degrees in public health and business administration, plus recent board certification in lifestyle medicine, set the stage for ongoing collaboration, innovation, and accomplishment.

Through member relevance and specialty unity we can achieve the unachievable and will continue to grow and shine as a specialty. I know what a gem our Academy is and how fulfilling participation can be; I want all members to benefit as much as I have. ■

“

The strengths of our Academy that will lead us forward are our diverse members, our incredible staff, and the synergy that flows from specialty unity.

”



Kathleen Yaremchuk, MD, MSA

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There are few of us who go a day without the use of Google, and much like that resource, the Academy needs to supply information to our members and be the go-to source for necessary materials.

”

The most important issue facing the Academy is maintaining relevance to otolaryngologists in a time of increasing subspecialization. Otolaryngology has grown in knowledge that benefits our patients in the ability to diagnose and treat many conditions with superior outcomes than previously imagined. The increase in specialization, however, has resulted in fragmentation within our specialty. Our specialty societies successfully promote scholarly activities and provide a home for their members. Often individuals have to choose between submitting presentations to their society or the Academy for purposes of career development.

We must make sure the Academy must maintain relevance. A definition of “relevance” is to maintain the ability to supply material that satisfies the needs of the user much like an information retrieval system. There are few of us who go a day without the use of Google, and much like that resource, the Academy needs to supply information to our members and be the go-to source for necessary materials. It needs to serve as the home for all otolaryngologists and will work on issues that are common and supply answers that are relevant. The pandemic was an example where the Academy served as a conduit for critical

information, government policies, and advice on providing care while protecting ourselves, our patients, and our families.

Aristotle observed, “The whole is greater than the sum of its parts.” That is true for our specialty and for the Academy, but we need to remain vigilant and continue to prove our value to all practicing otolaryngologists if we are to thrive going forward.

Otolaryngology has been exceptional in its ability to recruit the most talented medical students for residency. Because of this, we enjoy the opportunity to train exceptional residents who become leaders in the field of medicine, not just in otolaryngology. I am always amazed at the individuals in our field who go on to become deans of medical schools, CEOs of their health systems, and medical directors or chiefs of surgical service lines. We all have watched as the “best of the best of the best” from our specialty have grown and ascended in their careers to leadership positions at national levels.

This talent is what sustains the Academy and allows it to flourish. The membership is involved, articulate, and motivated. Academy members gain value from those who lead the way and are routinely ahead of the curve. We are learners, and the strengths of the Academy are its members who continue to give of their time, knowledge, and passion for each other. ■

Q: What do you see as the essential task of the Directors and in what ways are you well suited to that role?
A: What do you think is the most important issue that our Academy is currently facing?



Alexander G. Chiu, MD

our patients. Whether that is through direct patient care, research, and/or education, the Academy is a vital engine to coordinate, innovate, and represent our shared mission in an inclusive and equitable environment.

I've been a member for 25 years and have a somewhat unique perspective in having practiced in three very different parts of the country. I spent the first part of my career in Philadelphia, Pennsylvania, then moved to Tucson, Arizona, and now reside in Kansas City, Missouri. I've been fortunate to hold many leadership roles during that time period, including chairing the Departments of Otolaryngology at the University of Kansas and University of Arizona and serving one year as a surgery chair. I am the current editor of *ENT Today* and have built working

relationships with colleagues all across the country in private practice and academics and in both urban and rural settings.

Like all medical specialties, the Academy is in a time of change and needs to be mobile in adapting to the disruptions in the marketplace and the evolution to a more diverse environment where healthcare inequities need to be addressed. As industry support continues to decrease, we will need to find new and creative ways to engage our membership and support the education and research programs that are so critical in fulfilling our mission to provide the absolute best care to our patients. These issues are central to what I do in my daily work life and I am eager to help in any way possible.

Thank you for your support! ■

The Academy serves to represent the interests of *all* otolaryngologists, affiliated providers, and stakeholders. We are from different parts of the country, practice settings, and stages in our careers. But we share something very important and that is doing our absolute best to care for



Sanjay R. Parikh, MD

I have been fortunate to serve in Academy leadership roles as Chair of the Board of Governors and Chair of the Young Physicians Section. During these terms, I participated in two AAO-HNS strategic planning retreats and served on the Academy's Executive Committee and Nominating Committee. I have actively sought opinions from many grassroots groups including the BOG, WIO, YPS, SRF, IAB, and DIC. I feel particularly well suited for the position of At-Large Director as I have fostered successful collaboration between the diverse physicians and leadership of our membership.

Our Academy's greatest issue is active support of our membership during this historic pandemic. We have already seen extraordinary leadership

and community from our Academy and its members through responsive and adaptive attention to financial support for practices, development of new positions and paradigms for education, telehealth, research, and payment. But our work is not done.

As your At-Large Director, I will actively listen to your challenges and concerns and understand how the global pandemic has affected you. Our practices and loved ones have all been deeply shaken by this terrible year, and I would be sure to hear your perspective and thoughts on how our Academy may support you. The success of our Academy will hinge on understanding your needs. As we put these dark days behind us, we will work toward our best future together. ■

Essential to the success of the BOD is to carefully listen to ALL constituents and to steer the BOD toward members' greatest needs and concerns. I believe in responsive and representative leadership. In our AAO-HNS community, a successful Director listens and acts appropriately to all concerns from our membership.

Q ■ What do you see as the essential task of the Directors and in what ways are you well suited to that role?
■ What do you think is the most important issue that our Academy is currently facing?



Cherie-Ann O. Nathan, MD

My journey from a young international research assistant at Johns Hopkins University to the department chair has given me a unique perspective on practice, research, and education in a collaborative setting. The crisis has brought the world closer through virtual meetings, and we have a great opportunity to be the leader for the world in all these areas, including mentorship.

We need visionary, hardworking, reputed leaders, listeners, and effective communicators who can continue to help the Academy be the powerhouse that unifies and leads the diverse world ENT community. As one of the few minority female chairs leading a highly productive academic department that works closely with private and public hospitals in rural and urban areas in Louisiana, I believe I am uniquely equipped to help enact.

If given the opportunity, I will work hard on strengthening the bonds between academics and private practice while broadening our horizons in terms of gender empowerment and diversity, and incorporating the latest technologies with greater emphasis on our mission, which is always putting our patients and their wellness first.

Adapting and leading in the post-pandemic world is our highest priority at the moment. We have a unique opportunity to provide access to every corner of the world in terms of outstanding patient care, educational opportunities, and mentorship programs. I envision the Academy embracing the latest technologies in terms of apps, servers, robotics, and AI to become the global hub collaborating with all the societies and organizations. ■

Peter Drucker: "Management is doing things right; leadership is doing the right thing." We are emerging from one of the most disruptive events—a devastating pandemic that has impacted everyone. The world has changed dramatically, and the Academy as a world leader of our specialty is faced with the task of leading in the aftermath of this crisis.



Robert T. Sataloff, MD, DMA

with a self-employed clinical practice model.

As professor and chair and senior associate dean at Drexel University, I am employed for academic and leadership activities, but my clinical practice is independent. While being active academically (more than 1,000 publications, including 69 books, and journal editor), I have advocated for private practice interests. I also serve as the Academy's representative to the AMA for impairment (*AMA Guides*), spent more than 20 years on the Voice Committee (six as Chair), served as a member and Chair of the Geriatric Committee, have served on the Board of Governors for 16 years, have taught Academy courses, and presented papers and seminars for four decades. I have served in numerous other leadership capacities for the Academy and the specialty including president of the American

Laryngological Association, president of the American Society of Geriatric Otolaryngology, president of the Pennsylvania Academy of Otolaryngology - Head and Neck Surgery (PAO-HNS), and others. I remain active on the PAO-HNS Council and am involved actively in legislative and political advocacy on behalf of otolaryngologists. In addition, I proposed and helped initiate the AAO-HNS/F annual leadership meeting of state society presidents and executive directors.

I support all of the objectives in the Academy's strategic plan, but the most important is "quality." Developing and promulgating excellence is the foundation upon which all of our initiatives must be built, and doing so in the current environment is the most important issue that the Academy is facing.

I would be honored to help. ■

The essential task of an At-Large Director is to identify and help fulfill the needs of our specialty, while expanding recognition of the Academy's relevance and engaging otolaryngologists (academic and private) in our national organization. I hope to help by providing perspectives gleaned from a 40-year career in academic otolaryngology integrated

Q: What do you see as the essential task of the Directors and in what ways are you well suited to that role?
A: What do you think is the most important issue that our Academy is currently facing?



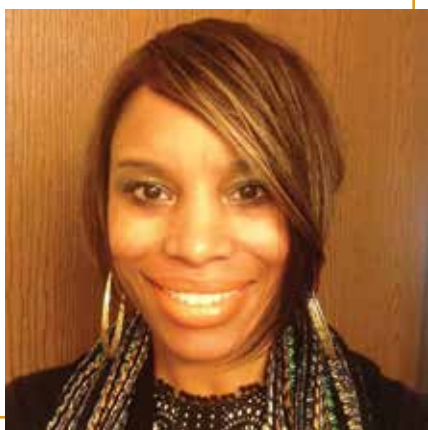
Jeffery J. Kuhn, MD, CAPT, MC, USN (Ret.)

The essential tasks of the Board of Directors are to assess the overall direction and strategic plan of the Academy, support the mission and vision of the Academy, and to establish new initiatives that forward the voice of the membership. The Board of Directors should identify and understand the most important issues facing the Academy. It is critical that the Directors have leadership experience and have demonstrated integrity, ingenuity, and

commitment in those leadership positions. I have served in a number of leadership positions in various venues including military academic and nonacademic centers, a university academic center, and now in private practice for the past six years. I have served on six Academy Foundation Committees and recently completed a three-year term as a member of the Nominating Committee, AAO-HNS/F.

As a former collegiate athlete, physical and mental wellness were paramount in determining performance outcome. Performance outcomes in our professional lives are similarly influenced by these factors. As much as we attempt to maintain personal wellness in our professional career while establishing a health-life balance, there is great potential for physical, emotional, and mental exhaustion. Physician burnout

has become an important issue throughout the medical specialties and should be a focus of attention within our Academy. Frequent changes in clinical practice involving EMR system platforms, telehealth policies, workload expectations, and administrative burdens, in addition to loss of independence and authority, heightened patient expectations, and a culture that emphasizes perfection are several factors that contribute to the erosion of physician well-being. I would expand the current Wellness Team initiative in the form of a task force that would interface with other Foundation Committees including Media and Public Relations, Telehealth, Practice Management Education, and Diversity and Inclusion in order to identify factors unique to the otolaryngologist and to propose evidence-based solutions. ■



Angela M. Powell, MD

Being an active-duty U.S. Navy ENT for almost 14 years, juxtaposed with my current rural civilian practice, have together reinforced the true value and necessity of member involvement and service to the Academy. The tenet that collectively we can achieve inordinately more in advancing excellence in the delivery of care

to our patients than any one of us could do individually has been aptly demonstrated in the Academy's response to the COVID-19 pandemic. Allow me to represent private practitioners and be your voice on the BOD as we work to reduce healthcare disparities in underserved communities, to continue legislative advocacy, to educate and promote lifelong learning, to increase diversity within the specialty, to promote wellness, and to engage and mentor young leaders. I have been involved in each of these areas through my roles in the SRF, on BOG Committees, chairing the Barnes Society, and as the Immediate Past Chair of the WIO. Thank you for your vote of support.

The importance of wellness to the Academy's primary initiatives cannot be overstated. Consider overcoming the

financial impact to our practices by the pandemic; office closures; the death of colleagues, loved ones, and patients; exhaustion; and burnout while the guidepost to normalcy remains elusive and the stage is set. EHR inefficiencies, navigating telehealth services, the new E/M visit guidance from CMS and how these changes will affect reimbursements (anticipating a net positive but implementation will serve as the true measure), and the uncertainty of what ENT practice will become in the post-vaccine era further heighten stress and angst for many. Wellness is inextricably linked to the love that we all have for this amazing field and, therefore, must remain in the forefront for the Academy's efforts to be meaningful and impactful as we educate, lobby, mentor, innovate, and lead. ■

Q ■ How will you select candidates for Academy leadership that best represent our diverse membership?
■ What experience do you have that will aid in selecting leaders that will advance the mission of the Academy?

SEAT ONE



Ronda E. Alexander, MD

Our Academy needs a balance of experienced and emerging voices to serve our membership. The lived experiences and practical expertise of those from historically marginalized perspectives can advance our mission when positioned to impact our actions and policies. Many of them are already leading other academic and identity-affiliation organizations, while others are the quiet engines behind them. These are the willing workers I want to call up into Academy service, better equipping us for a future in which we will face unknown challenges in the realms of public health, patient care, and advocacy.

As a former residency program director, I have seen the benefits of selecting strong introverted candidates, then cultivating an environment that doesn't disadvantage them, relative to extroverts. Many of the "best of the best" have been the quiet ones, and this reinforces the importance of breaking "type" when we look for excellence. My work with my state medical society has complemented this by highlighting the importance of moving from mentoring to sponsoring people whose spark I can see, even if they haven't yet. Having been a beneficiary of sponsorship, I'm looking forward to encouraging others to put their potential to good use within the Academy. ■



Samantha Anne, MD, MS

"Here's to the crazy ones, the misfits, the rebels, the troublemakers, the round pegs in the square hole, the ones who see things differently ..." This narrative from a popular tech company advertisement follows with a description of how these are the people who change things. The importance of thinking innovatively became clear to me especially during the past year. I believe that the way to capture these resourceful intellectuals is to draw from our incredibly heterogeneous membership to find leaders with integrity who have proven to be inventive trailblazers.

I have served on various leadership roles in the American Academy of Otolaryngology—Head and Neck Surgery, including on the Board of Directors (as Young Physician Section Chair) and on the Board of Governors (as Secretary and current Vice Chair of the Governance and Society Engagement Committee). In addition, I have been the Chair of the Women in Otolaryngology Section's Nominating Committee. This service afforded me the chance to observe the leaders, and the qualities that elevate them as successful advocates for our profession.

This experience along with my motivation to identify talented and innovative leaders, will guide me if I am given the incredible honor to serve on the Nominating Committee. ■

SEAT TWO



Ken Kazahaya, MD, MBA

It is wonderful that we have such diversity in the membership of the Academy. With the global nature of our specialty, our organization encompasses members from various practice settings, organizational structures, geographic locations, and demographics. There is also great diversity in the individuals themselves, inclusive of unique origins and experiences, ages, ethnicity, and orientation. Our Academy's strength is in our membership's diversity of thought, experiences, and culture. It is important to keep an open mind and be inclusive in selecting individuals who have the necessary talents, skills, and experiences to best lead our Academy while considering the merits and accomplishments of each individual.

I had the honor of being elected to the Nominating Committee for the American Society of Pediatric Otolaryngology. As part of the Nominating Committee, I participated in discussions regarding the various considerations prioritizing qualities and attributes that are important and optimal for the positions we were seeking to select nominees. It was essential to be able to succinctly and effectively summarize the candidates under consideration and support their candidacy. I advocated considering individuals for their qualifications and what they would contribute to the leadership of the organization. ■



Brendan C. Stack, Jr., MD

I will propose and advocate for Academy members for leadership opportunities who have great passion for our specialty and extending its impact to ALL of our patients and learners regardless of their background, identity, or circumstance. A record of demonstrated impact will be required for my nomination or support. I will seek consensus from among members of the nominating committee to ensure a quality selection with strong, broad support. I will take seriously that the selection of future candidate leaders as a crucial task to ensure that our organization represents our membership and flourishes into the future.

I have learned to recognize leaders from over 30 years of observation of both good and bad examples of leadership. Those experiences have both educated me, inspired me to seek greater understanding of GREAT leadership, and driven me to identify those characteristics crucial for inspiring successful leaders. My value of a strong and effective leader is profound and inspires me on my personal leadership journey. Moreover, having served in various leadership capacities within the AAO-HNS/F, the American Thyroid Association, and the American Head & Neck Society – Endocrine Surgery Section, I have learned the importance of leading by example, building and maintaining relationships, and making and keeping commitments. ■

Q: How will you select candidates for Academy leadership that best represent our diverse membership?
A: What experience do you have that will aid in selecting leaders that will advance the mission of the Academy?

SEAT ONE



Andrew M. Coughlin, MD

While the Academy has made strides in creating diversity within our membership, we have seen some but limited success in obtaining diversity at the leadership level. As a member of the Nominating Committee, I will work hard to not only focus on diverse backgrounds, practice settings, and experience levels, but I will also aim to promote those who have put forth significant effort in elevating those around them. Leadership is best exemplified by supporting and promoting your peers. Teamwork and an “others first” mentality will be at the forefront of my decision making.

As Chair of the Engagement Task Force for the Young Physicians Section, past governor of the Nebraska Academy of Otolaryngology, and as a member of the Nominating Committee for the Metro Omaha Medical Society, I have a lot of experience in encouraging and mentoring strong candidates for positions of leadership. It is my hope that I will continue this work for the greater good of the Academy to make our entire community more impactful and representative of all otolaryngologists and the patients we serve. I very much appreciate this opportunity and promise to represent you all to the best of my ability. ■



Darius Kohan, MD

During my 30-year career in private practice and academics, I had the privilege of collaborating with colleagues from all aspects of otolaryngology throughout the United States. Participating in numerous BOG and AAO-HNS Committees, I got to know and appreciate the outstanding dedication and leadership quality demonstrated by our members. In private practice, especially during the pandemic, I am familiar with all the challenges facing us and the opportunities available for improving the welfare of our patients and the well-being of the otolaryngologists attempting to optimize patient care. Participating in regional and national efforts to promote Academy goals, educate the next generation of otolaryngologists, and improve patient care, while collaborating with our peers in all fields of medicine, allowed me to personally become familiar with the large pool of talent available to the Academy. Their work ethic and dedication to benefit the welfare of our patients and achieving Academy goals was amply demonstrated. I intend to nominate the most deserving otolaryngologists to leadership positions based upon merit and ability to represent our evermore diverse membership. Leadership must reflect the needs of both private practitioners and academicians, the geography and demographics of our country, and the vision of the Academy for a brighter future. ■

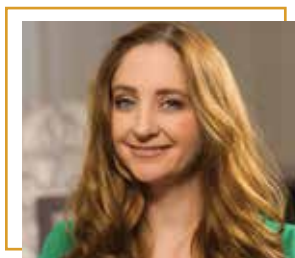
SEAT TWO



Russell B. Smith, MD

We are fortunate in otolaryngology-head and neck surgery to have a very diverse and engaged membership. We currently have a large number of these talented surgeons involved at many levels throughout our society. I would plan to recommend candidates for Academy leadership by recognizing these currently engaged members, many of whom I have worked with on a variety of education and program committees in my 20 years of involvement with AAO-HNS. I would also reach out to these members for recommendations of up-and-coming younger members who will be able to positively contribute to the ongoing success of our Academy.

Over my years of experience with residency and fellowship training programs, hospital governance, and medical practice development, I have been involved with selecting individuals to be part of a team to move forward the mission of an institution. Through these experiences, I feel that I understand that leadership requires a diverse team of individuals with uniquely different skills to be successful. I plan to use these experiences to recommend candidates with a wide variety of skills to fulfill the needs of the different leadership positions within our Academy. ■



Angela K. Sturm, MD

As a member of the Nominating Committee, I would be excited to have a hand in choosing leaders who represent our membership professionally and personally. It is important to bring voices to the table with different perspectives. In the environment of reimbursement challenges, increasing overhead, changing protocols, increased expenses for the pandemic, and complex patients, the private practice physician's representation is critical. As the owner of my own private practice, I understand those challenges. In addition, I am sensitive to how those physicians' time spent away from their practice must be optimized to retain engagement. We also need to keep in mind the demographics of our membership currently and where we anticipate growing. As our membership is more diverse, we need leadership that reflects that and understands unique challenges that they may have. I have spent a large portion of my career working for diversity and inclusion, from giving lectures on the healthcare needs of gender minorities to furthering discussions about how to improve healthcare delivery for racial minorities. I appreciate the wisdom from those who know where we have been and gain inspiration from those who are our future. ■



What is your particular experience or interest that would make you an effective member of the Audit Committee of the Academy?



Art A. Ambrosio, MD, MBA

A guiding principle in the U.S. Navy is “Ship, Shipmate, Self.” I have been an active member and advocate on behalf of AAO-HNS/F, prioritizing it in my career as my “Ship” since early in my surgical residency, serving on the BOG Legislative Affairs and Governance & Society Engagement Committees—allowing me to understand and protect the strategic mission of the Academy on a local, state, and federal level.

Completing formal business training at UNC Kenan-Flagler Business School in addition to my full-time surgical practice prepared me for involvement in Navy enterprise-wide leadership roles. A major venture has been in founding the first-ever

virtual Naval Medical Center (VNMC) in San Diego, California, which supports tri-service military medical treatment facilities as well as deployed ground and fleet forces throughout the entire Pacific Rim. As deputy director of the VNMC, I have provided thorough operational oversight of security, policy, and budget allocation for the programs we have built within this rapidly scaling venture during the COVID-19 pandemic.

I am ultimately looking to leverage my strengths, energy, and passion to serve the Audit Committee—ensuring transparency and attention to detail to ensure that our precious resources are properly supporting the mission of the Academy and its members. ■



Steven B. Levine, MD

The Audit Committee is the entity that maintains transparency of the operational and financial condition of the Academy. It is a critical function.

I have been a member of the Academy since the mid-1980s and have been faculty for Academy instruction courses and served on the Practice Management Committee, Professional Liability Committee, Certificate Program for Otolaryngology Personnel Committee, Ad Hoc Committee on an Otolaryngology Risk Retention Group, and Physician Resources Committee. I have been active on the BOG, including election as Secretary as well as Vice Chair of the Socioeconomic & Grassroots Committee.

My medical career has all been in private practice, including group practice with multiple offices and solo practice of late. My interests outside of my medical practice, however, have afforded me a broader experience and scope of understanding of the operations of various businesses. I have started several companies that categorize me as an entrepreneur and am a cofounder of the Society of Physician Entrepreneurs. I have been a director of a publicly held bank and served on its loan committee, thus affording me unique experience interacting with both internal and external auditors. These interests and experiences support my candidacy for this position. ■

Tracheostomy Care

Lacey K. Adkins, MD, Laryngology and
Bronchoesophagology Education Committee
member

Tracheostomies are one of the most-performed surgical procedures, and the incidence



has continued to rise. Tracheostomy care is a broad topic that includes patient and caregiver education, postoperative care, and decannulation protocols. It is a complicated process that requires the otolaryngologist to work as part of a team on behalf of the patient. It has recently been identified as a practice management gap.

Tracheostomy care begins in the immediate postoperative period. Tracheostomy ties should be used unless there is a surgical contraindication such as free flap reconstruction. Velcro or twill ties may be used with no consistent difference in skin-related complications or decannulation rate.¹ Stay sutures may decrease the incidence of accidental decannulation in fresh tracts.^{2,3} They should be tied with air knots and removed within seven days to avoid excess pressure and resulting pressure ulcer formation.

Pressure ulcers occur in 10%-30% of tracheostomies.^{4,5} Having a set tracheostomy care protocol, especially one that involves a multidisciplinary team to identify and provide wound care, helps reduce their incidence. Moist dressings applied peristomally result in a lower incidence of pressure ulcers, shorter wound closing times, and less frequent dressing changes.⁶

In the early postoperative period, secretions are more copious. Frequent suctioning and care with saline flushes as needed are key to avoiding mucous plugging.⁷ Humidification should be used to help

Tracheostomy Care is a complicated process that requires the otolaryngologist to work as part of a team on behalf of the patient. It has recently been identified as a practice management gap.

mobilize secretions. Prior to cuff deflation and tracheostomy change, the tracheostomy and stoma should always be suctioned.⁸

A multidisciplinary tracheostomy team not only reduces wound complications, but improves time to decannulation, decreases the length of stay, reduces adverse events, and increases speaking valve usage.⁹ A consistent approach with adequate staff training and early coordination of care can help patient and caregiver education, as well as the discharge process.¹⁰ Patients and caregivers must learn and demonstrate essential tasks before being discharged, including hands-on tracheostomy care training with simulation of emergency situations.⁸

Early involvement of a speech-language pathologist leads to earlier phonation and transition to an oral diet. Some patients can tolerate early cuff deflation and in-line speaking valve placement while still receiving mechanical ventilation safely.^{11,12} Once off mechanical ventilation, the cuff should be deflated or the tracheostomy changed to an uncuffed tube to decrease further tracheal pressure injury.⁸ This also allows for phonation with a one-way speaking valve. If the patient has an appropriately sized tube and is unable to tolerate the valve, the upper airway needs to be examined to evaluate for any abnormalities. If they can tolerate a valve but the voice is soft, a fenestrated tracheostomy tube may allow more air to reach the glottis. However, they require close monitoring as patients can develop granulation tissue at the site of fenestration

that needs to be managed before leading to airway obstruction.¹³ One could argue that the choice of a fenestrated tracheostomy would be best made with the consultation of an otolaryngologist.

For patients who require long-term tracheostomy dependence, biofilms and the tracheal environment eventually lead to hardware degradation. Frequent tracheostomy change may result in less granulation tissue formation. Tracheostomy manufacturers have recommended changing intervals with their products, which is usually one month. In the literature, there is extensive variability on recommended intervals ranging anywhere from two weeks to every three months and especially whenever the tube begins to change color or has visible degradation or cracks.^{14,15}

For weaning and decannulation, having a set protocol leads to a higher rate of decannulation during the hospital stay and a decreased time to decannulation.^{9,16} Before decannulation, the patient should no longer require mechanical ventilation and have no further procedures planned, an intact cough reflex and an appropriate mentation and laryngopharyngeal function to protect themselves from aspiration. A capping trial should then be started with an uncuffed, appropriately small tube in place and may last anywhere from 24 to 72 hours depending on surgeon preference. The upper airway should be examined prior to decannulation as well by at least laryngoscopy and tracheoscopy. In patients who tolerate capping trials for 24 hours, up

to 20% have lesions on endoscopy that are a contraindication to decannulation.¹⁷

After decannulation, follow-up is needed to assess for tracheocutaneous fistula closure and to monitor for any stenosis symptoms. Roughly 1%-2% of patients will report symptoms of benign tracheal stenosis after decannulation, whether from scarring, tracheomalacia, or A-frame deformity, usually after a delay of two to three months.¹⁸

In conclusion, tracheostomy is an increasingly common procedure that has extensive care associated with it. The biggest step to take toward improving outcomes is to establish a multidisciplinary tracheostomy team that follows the patient in the hospital as well as a plan for follow-up post discharge. With non-otolaryngologists performing tracheostomies, the otolaryngologist has an important role to play in follow-up planning. This helps to facilitate appropriate wound care, progression toward decannulation, and patient/caregiver education. ■

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Improving Safety by Studying Why Things Go Terribly Right

Ellen S. Deutsch, MD, MS,
PSQI Committee member

Do humans cause patient harm, or do we prevent it? Efforts to improve patient safety have—appropriately—received a lot of attention and resources over the past two decades, with some progress but many remaining challenges.¹⁻³

Like the note on the stop sign in the photograph to the right, sometimes looking at our activities from a different perspective can change our understanding, and a fresh perspective might increase our appreciation for the work that we do every day to optimize patient safety.

Safety-I

The traditional perspective on patient safety, Safety-I, is generally based on the belief that we should investigate healthcare events in which patients were harmed, figure out what failed, and build in barriers to prevent recurrence. When there is an unwanted outcome, we expect to find breaches in protocols or other defenses that caused—or at least allowed—the problem to occur. Humans are often seen as a liability or hazard, and we expect optimal outcomes if processes are standardized and healthcare workers behave as trained.^{4,5} However, patients may not do well despite our most learned and skilled efforts, and patients sometimes do well for reasons that we don't completely understand. There is a complementary perspective, Safety-II, which seeks to learn from what went right, acknowledges complexity, and values adaptation.



Safety-II

The majority of patient care interactions go well. This is not to say that we shouldn't always look to improve and recognize our shortcomings, but there can also be value in understanding and augmenting successful processes. The Safety-II perspective advocates for deliberate investigation to understand what decisions, actions, or adaptations contributed to successful patient outcomes.⁴ Understanding whether the desired outcome resulted from our ability and effort, rather than from luck,⁶ can help improve care going forward.

What can we learn from studying what went well? Examples from other fields are

never quite sufficient, but still may offer perspective. K. Anders Ericsson, famous for describing the importance of deliberate practice to achieve expert performance, posits that improvement is based not just on repetition, but also requires explicit exposure to the best method.⁷ Shmuel Ellis and Inbar Davidi found the performance of soldiers who were debriefed on their successes as well as their failures during successive navigation exercises showed greater improvement than soldiers who reviewed their failed events only.⁶ This makes sense in healthcare also, such as when developing surgical skills. Learners (all of us!) need to understand what we have done right as well as what we may need to improve. This understanding of what went well goes beyond the kudos received for an extraordinary job well done and involves an effort to learn why.

Safety-II also posits that adaptation—performance adjustment—is both necessary and ubiquitous.⁴ We provide healthcare despite work conditions that are both dynamic and underspecified. The impact of factors that can impair performance may be momentary but recurrent, including competing demands, production pressure, and resource limitations. Successful patient care results from innumerable small adjustments, often unrecognized, or, in rigid systems, accomplished surreptitiously. In this perspective, humans are not liabilities to be managed, but are important resources who contribute to system flexibility and resilience.⁴

Although not always explicitly recognized, many organizations have responded to the COVID-19 pandemic with behaviors that exemplify Safety-II



and resilience engineering principles. Providers have self-organized groups that convene by video conference call and share information about process improvements and lessons learned to proactively minimize risk and improve safety for both patients and providers. Organizations have implemented simulations to develop and revise patient care protocols, refine methods to correctly don and doff personal protective equipment, and enhance communication between providers despite physical barriers necessitated by isolation practices.⁸

Safety-II Is a Frame Shift

Maintaining a Safety-II perspective, which reinforces correct decisions and actions, sometimes takes conscious effort. For example, when debriefing participants in simulations, it is easy to criticize whereas seeking to surface and understand tacit knowledge and constructive actions often requires intentional reorientation.

The Safety-II approach is also applicable to ordinary processes. It can be difficult to expend energy understanding everyday activities in addition to exceptional successes or failures; however attention to commonplace processes, because of their frequency, may provide the greatest benefit.

Finally, consistently modeling respect

and appreciation for colleagues' actions and perspectives provides an affective lesson; and learning from success can help us appreciate the value of system capacities and resources that might otherwise be lost in efforts to constrain costs.

Safety-I and Safety-II Can Co-Exist

Can these different approaches be reconciled? Healthcare delivery is a complex adaptive system; interactions and conditions constantly evolve and are incompletely knowable. The Safety-I approach of fixing each part of a system in a mechanistic fashion does not always guarantee that the whole will work as desired, but there are circumstances in which standardized protocols are optimal. Conversely, there are inevitable gaps between idealized "work-as-imagined," which often informs policy, and actual "work-as-done,"^{4,9} which is the experience of providers at the "sharp end." We can seek to improve by understanding and appreciating the knowledge, skills, behaviors, resources, and environments that contribute to success, and by recognizing the value of adaptive solutions. The Safety-II approach helps develop resilient capacities that support continued and safe healthcare delivery despite small or large perturbations.¹⁰ Healthcare delivery

involves unique high-hazard processes, and the complementary perspectives of Safety-I and Safety-II can both contribute to providing the safest patient care. ■

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ASPIRATION

Aspiration is a medical term for accidentally inhaling your food or liquid through your vocal cords into your airway, instead of swallowing through your food pipe, or esophagus, and into your stomach. Once past the vocal folds, the food or drink enters your windpipe, or trachea, and can pass into your lungs. It happens sometimes to healthy people who have food “going down the wrong pipe” while swallowing. When this happens, a normal voice box, or larynx, and trachea sense the food or drink, which triggers a strong cough to clear the item from your windpipe and protect your lungs.

WHAT ARE THE SYMPTOMS OF ASPIRATION?

When swallowing becomes difficult, or the sensation of your throat or voice box becomes impaired, anything that passes through your mouth can get into your lungs, even saliva, which is full of bacteria. Symptoms of aspiration may include:

- Strong coughing
- Choking while eating
- Pneumonia
- Trouble swallowing
- Stress while eating
- Weight loss

Again, aspiration is of great concern because it increases your risk of developing pneumonia.

WHAT CAUSES ASPIRATION?

Aspiration can happen for many reasons and often should be looked at by an ENT (ear, nose, and throat) specialist, or otolaryngologist. If you have frequent coughing while eating or drinking, this is a sign you should see a doctor about swallowing problems. Given the possibility that aspiration might lead to pneumonia, finding it early is important. Sometimes when a stroke or other condition makes the vocal cords less sensitive, coughing may not be a signal that you are having difficulty swallowing, which can lead to silent aspiration.

WHAT ARE THE TREATMENT OPTIONS?

Doctors often ask other healthcare providers such as speech-language pathologists (SLP) to help test swallowing problems. They may use a small camera placed through the nose to examine how food passes by the voice box into the esophagus during a swallow. Testing may also include a special X-ray video, called a modified barium swallow. This allows the SLP and doctor to watch the food pass through the entire swallowing activity from lips to esophagus. These tests may show what is wrong in the swallowing process, and help them figure out how to help you eat and drink safely.

Sometimes, simple diet changes are all that is needed to prevent aspiration. Other cases may need swallowing therapy. During therapy, exercises for swallowing strengthen and coordinate the muscles used in swallowing. Some swallowing problems may need surgery. Unfortunately, in certain situations, swallowing is so difficult or unsafe that a person cannot take in any food or drink by mouth. Then, interventions like a stomach feeding tube can supply food and fluids. In these situations, your doctor(s) and clinical team will work to help you find treatment(s) to regain a safe, effective swallow.

If you have any questions or concerns about suspected aspiration for you or a loved one, please find a nearby ENT specialist for consultation.

WHAT QUESTIONS SHOULD I ASK MY DOCTOR?

1. What is the difference between choking and aspiration?
2. Do you know why I have difficulty swallowing?
3. What are the tests for my swallowing problem?
4. Did I get pneumonia from aspiration?
5. What is the treatment for aspiration?
6. What is the oral care regimen for people that aspirate?
7. Do I need a feeding tube?
8. What is swallowing therapy?

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The Ohio State University
Department of Otolaryngology – Head and Neck Surgery

BC/BE Rhinologist

Seeking an academically productive Rhinologist for a clinician/scientist position in the Department of Otolaryngology – Head and Neck Surgery at The Ohio State University. Applicants must be board certified/board eligible, fellowship trained, and demonstrate excellence in research, teaching, patient care, and leadership. This is a tenure track position in which all ranks will be considered and leadership opportunities are available for qualified applicants. The ideal applicants must be highly motivated to set up a successful clinical or basic research effort, work well independently, and be funded or on track to submit for NIH or equivalent funding.

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Interested applicants should send a letter of interest and CV to:

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



CLINICAL FELLOWSHIP IN LARYNGEAL SURGERY AND VOICE DISORDERS Massachusetts General Hospital

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

Direct inquiries to:

Steven M. Zeitels, MD, FACS
Eugene B. Casey Professor of Laryngeal Surgery
Harvard Medical School

Director: Center for Laryngeal Surgery & Voice Rehabilitation
Massachusetts General Hospital
One Bowdoin Square, 11th Floor
Boston, MA 02114

Telephone: (617) 726-0210 Fax: (617) 726-0222
zeitels.steven@mgh.harvard.edu



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