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

JUNE 2021

Annual Meeting Registration Opens June 21

23

AAO-HNS
CELEBRATING

125

YEARS

1896 - 2021

Education

Wellness

Diversity,
Equity, &
Inclusion

Leadership
Development &
Mentorship

SHAPING OUR FUTURE
TOGETHER

125 STRONG CAMPAIGN

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Advocacy:
RepresENTing You!

16



"Manage your ENT practice better and achieve better outcomes for your patients."

– Dr. Elledge



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Dianne Williams

"The value of **ASCENT** (**A**dministrator **S**upport **C**ommunity for **ENT**) is immeasurable.

The website alone is a fortress of information and learning opportunities, but nothing compares to the networking and collaborating that it affords you and the subsequent friendships that follow."

Dianne Williams

CEO - ENT Assoc. of Alabama, P.C.



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When our administrators can have discourse and exchange ideas with other practices we all benefit: sometimes it's best practice information on how one group has solved a given issue, or a group letting others know of a problem to help them avoid the same.

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Vice President - ENT Associates of Alabama, P.C.

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The Value of Mentors, Role Models, Sponsors, and Coaches in Otolaryngology

"If I have seen further, it is by standing on the shoulders of giants."

— Isaac Newton

I have been remarkably fortunate to have a wonderful professional career as an otolaryngologist who specializes in head and neck cancer surgery. I have also been blessed to have been given the opportunity to hold many important leadership positions: Chair of the Department of Otolaryngology-Head and Neck Surgery at the University of Michigan Medical School, Dean of The Ohio State University College of Medicine, and President of the American Academy of Otolaryngology-Head and Neck Surgery. As I reflect upon my own career to date, I truly believe that none of this would have been possible without mentors, sponsors, role models, and coaches. Let's begin with some definitions. Mentors provide guidance while role models offer an example. Sponsors afford opportunity while coaches empower us to be our best selves.

I had the privilege of serving as the Chair of the Women in Otolaryngology Leadership Development and Mentorship Committee from 2012 to 2018. Further, I have had the privilege of serving as a mentor to many otolaryngologists around the country and world. Strong mentorship enables each of us to grow, to learn, and to both create and accomplish our goals. A mentor needs to be available, actively listen, give honest and objective feedback, and both motivate and challenge the mentee to be their best self. In today's complex world of medicine, whether academic, blended, or private practice, having a mentor can mean the difference between success and failure.

So what's in it for the mentor? Serving as a mentor can provide a renewed sense of meaning and purpose when one has the opportunity to make a positive difference in a colleague's life and career. The mentor also has the opportunity build a collaborative partnership with a talented colleague. Perhaps most of all, a mentor derives great satisfaction by contributing to a legacy of developing the next generation of colleagues and otolaryngologists.

Sponsors are those individuals in your life who put your name forward for important roles and responsibilities. They believe in you and are confident in your ability to be successful. We all need these

people in our lives and careers. Networking at our AAO-HNSF Annual Meeting & OTO Experience is a great way to find sponsors. The Academy has a vast array of committees, and participation on a committee is a great way to get involved.

Some of you may know that I am the mother of a former collegiate gymnast who subsequently worked as a volunteer coach of her college gymnastics team. This circumstance gave me a fabulous opportunity to truly appreciate the value and importance of coaches. I have also had the privilege of working with an executive coach when I took on new leadership roles. Coaches are really special people. They have a unique way of helping us gain insight into our strengths and our weaknesses, while instilling confidence. A coach is someone who can give correction without causing resentment.

Finally, role models are those people who you look up to and aspire to emulate. One of the role models in my career was the late **Charles J. Krause, MD**. He served as the chair of the Otolaryngology Department at the University of Michigan from 1977 until 1992. He also served as Past Treasurer and Past President of our Academy. I had the privilege of holding the Collegiate Professorship created in his name and honor from 2012 through 2018. Chuck was described as being a gifted surgeon and mentor. Ever the calm and thoughtful visionary, he served our profession with distinction.

Leadership development and mentorship is one of the project areas that is part of our **125 Strong Campaign**. There are many important mentorship initiatives being launched. Our Young Physicians Section is launching a peer mentorship initiative at the upcoming AAO-HNSF 2021 Annual Meeting. mENTor, which is a new AAO-HNS program that connects medical student members to practicing otolaryngologists around the country, started in May and already has 234 students and 155 volunteer mentors signed up. It is gratifying to see the dedication and willingness to help others during disruptive times. For more information and to get involved, visit the [AAO-HNS website](https://www.entnet.org/AAO-HNSF).

The future of our specialty is bright due to the tremendous numbers of mentors, sponsors, coaches, and role models who are members of the Academy. Thank you for all you are doing to advance our field. ■



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

“The future of our specialty is bright due to the tremendous numbers of mentors, sponsors, coaches, and role models who are members of the Academy. Thank you for all you are doing to advance our field.

”



OTO Journal

**CALL FOR
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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

Relevant topics for consideration include:

- Social Determinants of Health
- Diversity, Equity, and Inclusion in Medical Education
- Health Disparities in Vulnerable Populations
- Development of a Diverse Workforce in Otolaryngology-Head and Neck Surgery
- Health Policy and Inequality
- Promoting and Facilitating Diversity in Leadership
- Structural Racism and Inequity
- Economic Drivers of Healthcare and Their Implications
- Ethical Implications of Inequity in Health and Society

Deadline: December 20, 2021, at 11:59 pm (ET)

Submit papers for the themed issue at

www.editorialmanager.com/otohns

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

The Complexity of Advocacy

There continues to be positive news with respect to declining rates of COVID-19 infections and hospitalizations in most areas of the United States. The overall trend as the vaccination effort continues is a relaxation of restrictions that were put in place to help control the pandemic. At the same time, we recognize that this is not the case worldwide with certain areas continuing to suffer greatly because of the COVID-19 virus, and we continue to share information, tools, and resources with our global otolaryngology community.

While we typically launch registration in May for the AAO-HNSF Annual Meeting & OTO Experience, we delayed this year's registration until June 21 as we wait for more concrete information about what would be allowed in California, specifically Los Angeles, in terms of convention activity. The most recent guidance from Los Angeles would allow our convention to take place at the scheduled time in October with certain precautions. If the trend continues, it is likely that these restrictions will be lessened throughout the summer. We fully intend to hold an in-person meeting with a virtual component that will allow those, around the globe who are unable to attend, to experience a great education event with meaningful opportunities for networking and interacting with your colleagues.

As you will see in the *Bulletin* and as you review the program, **Daniel C. Chelius, Jr., MD**, and the Annual Meeting Program Committee have done a superb job in putting together an exceptional, innovative program with several new feature events such as the Great Debates, the ENTpreneur Faceoff, and the Personal and Professional Development Track. In addition to the 125th Anniversary Annual Meeting celebration special events already described, we will be announcing an exciting new program in the upcoming July *Bulletin* that will be initiated at the meeting in Los Angeles. Stay tuned!

Advocacy has never been more important than it is now and will continue to be over the next five to seven years as the healthcare delivery system is reshaped through legislation and regulation at a rate unseen in recent times. Our Strategic Planning process and the Board of Directors have recognized the need to designate additional resources to this area as a whole and specifically to the Business of Medicine. We have added a new director to our Advocacy team who will lead this effort in concert with our Education and Communications teams, the Physician Payment Policy

(3P) Workgroup, specialty-based otolaryngology, and other healthcare organizations. You can access the Strategic Plan at <https://www.entnet.org/content/strategic-plan>.

The complexity of advocacy engagement—whether it be state or federal legislation, state or federal regulation, health policy or government or private payer payment issues—has increased dramatically over the past several years, particularly the strategic use of social media. This makes the identification and prioritization of issues, choice of advocacy partners, development of both short- and long-term strategies, and effective communication of the issues and recommended solutions to our members and the legislators, regulators, and payers essential. Success can only be achieved through persistent collaborative effort by informed volunteer members and the dedicated advocacy staff.

“All that shines is not necessarily gold” is an old saying that is particularly applicable to the current world of advocacy. Many laws, plans, policies, rules, and regulations, which may appear appealing and beneficial on the surface, carry unintended consequences that in turn lead to long-term changes that are counterproductive to the advocate's goals.

There has been a marked uptick in private payer policy alterations over the last several years. The most common policy shifts involve pre-authorization, surgical indications, the -25 modifier, cerumen management, diagnostic procedures, and reimbursement rates. The lack of clarity in the recently enacted E/M coding changes has also caused additional stress for both government and private payer billing. Our ability to successfully address many of these problems is dependent on our members notifying us as early in the process as possible. There are many opportunities for members to get involved in our Advocacy team. The Board of Governors is an excellent place to start.

The cover of this month's *Bulletin* features our **125 Strong Campaign** and the four areas of focus for this initiative, which we hope will raise money for additional programs in Diversity, Equity, and Inclusion; Education; Leadership Development and Mentoring; and Wellness. **Angela M. Powell, MD**, has written an excellent article on the opportunities that exist in the diversity space that deserve your consideration. I would encourage everyone to take a close look at all four areas and donate to the one(s) that speak to you. ■



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

“Advocacy has never been more important than it is now and will continue to be over the next five to seven years as the healthcare delivery system is reshaped through legislation and regulation at a rate unseen in recent times.”



The Power of One Gives Strength to Many



James C. Denny III, MD
AAO-HNS/F Executive Vice President and CEO

YOU are the hero in the Academy's story and throughout our rich 125-year history, you have helped to get the work done through your generous support. Looking back on the AAO-HNS/F journey and the breadth of accomplishments of our small but mighty specialty, it has always been the commitment and involvement of members in the work of the Academy that has moved us forward.

Celebrating such a momentous milestone as we are with our 125th anniversary, causes one to pause and reflect on the path we have taken. It has reminded me of the long lineage of people who have contributed over the years to build and shape the specialty and our organization to what they are today. Dedicated and forward-thinking leaders have helped set the course for otolaryngology to expand and thrive through innovation and research, consistent education programming, and a continued focus on quality patient care.

There is no question that our specialty and organization have been blessed with exceptional leadership over the years. However, from the first days in 1896, the common denominator to our extensive efforts and achievements has been YOU—the hundreds of volunteers creating education products, developing new medical and surgical treatments, researching new frontiers that allow improvement in care and then providing that care consistently to

patients across the United States and around the world. Without YOU, we would have not been able to evolve to one of the most dynamic specialties in medicine today.

While effective leaders can help chart the future direction, real change only occurs when many make it happen. As new challenges are identified and plans made, the real work is done by the hundreds of volunteers, educators, and clinicians bringing the best available to their patients. Sharing this great responsibility in such a collective way allows more to be done without overwhelming any one individual.

As part of the **125 Strong Campaign**, four areas where our specialty needs to evolve to meet the needs of our members and the public today have been identified, but they need additional funding to be accomplished. These investment areas for the growth and future health of our specialty and those who compose it include Diversity, Equity, and Inclusion; Education; Leadership Development and Mentorship; and Wellness.

It has been amazing what our small specialty has been able to accomplish in the house of medicine and in patient care. Your support today will help us secure a better tomorrow for otolaryngology-head and neck surgery and those who dedicate their lives' work to patient care. We will all be surprised how quickly it adds up and will trigger a wave of support that can then make a profound difference.

Learn more at www.entnet.org/125Strong. ■

125 STRONG CAMPAIGN

Invest in a New Frontier of Research in Healthcare Disparities *Cultivating the Next Generation of Diverse Leaders*



Angela M. Powell, MD

Chair, 125 Strong Campaign, Diversity, Equity

The 125 Strong Campaign is awaiting your individual contribution to the future of the specialty in support of diversity, equity, and inclusion (DEI) focus areas that draw the intellect toward discovering how social determinants of health (SoDH) adversely impact the patients we serve. Barriers to achieving health equity are largely tied to these social and demographic factors that include, socioeconomic status, health insurance status, and race/ethnicity of which each play a pivotal role by influencing outcomes, access, and adherence to treatment.

Disparities in health equity have been magnified during the COVID-19 pandemic, highlighting higher rates of comorbidities in certain populations that directly correlate

with more severe clinical presentations, delays in accessing and seeking necessary medical care when infection is suspected, financial constraints reflective of the wealth gap in the United States, and general mistrust of the healthcare system, which have led to increased morbidity and mortality among underrepresented minority and marginalized patients. By supporting CORE grants researching healthcare disparities and SoDH in otolaryngology, together we will drive innovation that improves access to otolaryngic care for marginalized, underserved communities.

We are looking to advance beyond discussion to actions that can lead to real change through effective research, programs to increase exposure to otolaryngology through Annual Meeting and away rotation travel grants, complimentary passes to the Annual Meeting for local high school and college students, and affordable AAO-HNS membership.

Juxtaposed to our focus on inequities found in the provision of patient care and looking ahead, will the membership in attendance for the AAO-HNSF 2030 Annual Meeting & OTO Experience be as diverse as the populations that we serve globally today?

What if:

- The travel grant that you helped to fund allowed a student currently underrepresented in medicine to complete an away rotation or present a research project during the Annual Meeting?

- That research was particularly relevant to the community of origin into which the student intends to return after completing their residency training?
- You could mentor and train the next student to be the first in their family to complete a residency program in otolaryngology because of a pipeline opportunity that was created through funded travel sponsored by the Academy?
- Your name was listed in the rolls of donors choosing a path toward inclusive diversity and equity over the next two years?

Know that your pledge of support will make a difference in the lives of our patients and future otolaryngologists with diverse backgrounds!

As the Chair of this arm of the campaign and as a member of a community that is currently underrepresented in medicine being an African American woman, there is no better time than now—as I look at my practice in a rural community and the needs of this population with limited access to physicians and subspecialty medical care and I surf the news headlines—to use our collective will to give from our hearts in support of the specialty. There is a generation of diverse leaders waiting to be cultivated and a new frontier of research in healthcare disparities waiting to be written. We can only meet our goal of \$750,000 toward DEI focus areas in the **125 Strong Campaign** with a gift from each of us. Please join me and contribute today! ■

■ milestone moments



November 14, 1984: The first formalized AAO-HNS Legislative Briefing Day was organized.

1988: The Legislative Key Docs Program was created. It included a key contact in each state who tracked legislation affecting otolaryngology. Now referred to as the State Trackers Network, this program has grown to 173 physician volunteers who worked on 2,290 state legislative and regulatory proposals in 2020.

1989: The AAO-HNS Health Policy Commission was formed.

1995: ENT PAC was formed under the leadership of **Eugene N. Myers, MD, FRCS Edin (Hon)**, and chaired by **John A. Devany, MD**.

2002: The Physician Payment Policy (3P) Workgroup was formed to coordinate payment activities and actions including code updates.



Mark Your Calendar: AAO-HNS/F Grant Process Opening Soon!

AAO-HNS/F provides a variety of annual grants to residents, young physicians, and medical students. The grant application process will open soon for the following:

Diversity Endowment URM Away Rotation Grant

The Diversity and Inclusion Committee introduces medical students from under-represented minorities (URM) to the field of otolaryngology. Grant recipients receive \$1,000 to use toward travel, housing, food, and other expenses during their away rotation.

The Harry Barnes Endowment Travel Grant Application

In collaboration with the AAO-HNS Diversity and Inclusion Committee, the Harry Barnes Society provides travel grants to assist with needed funding for meritorious young residents of African descent from the United States, Caribbean, or Canada to participate in the AAO-HNSF Annual Meeting & OTO Experience.

Medical Student Travel Grants

Travel grants to the AAO-HNSF Annual Meeting & OTO Experience are available

to medical student members to learn more about the specialty, to meet and network with thousands of otolaryngologists from around the world, and to provide a foundation for continued learning.

Resident Leadership Grants

Resident travel grants help defray the costs of attending the AAO-HNSF Annual Meeting & OTO Experience and make it possible to learn and connect with the global otolaryngology community.

YPS Travel Grants

Young Physician Section (YPS) grants subsidize the costs of attending the AAO-HNSF Annual Meeting & OTO Experience. These grants are exclusively for young physicians in the first five years of practice.

For more information, please contact Pamela Gilbert at pgilbert@entnet.org. ■

Announcing the International Advisory Board (IAB) Chair-elect: Sheng-Po Hao, MD

Sheng-Po Hao, MD, a specialist in both head and neck surgery and skull base surgery, is professor and chair of the Department of Otolaryngology of Shin Kong Wu Ho-Su Memorial Hospital and program director of Otolaryngology in Fu Jen Catholic University in Taiwan.

Dr. Hao was the AAO-HNSF 2014 Eugene N. Myers, MD International Lecture on Head and Neck Cancer and the recipient of the 2017 Nikhil J. Bhatt, MD International Public Service Award. In 2013, he gave the keynote lecture at the 20th World Congress of the International



Federation of Oto-Rhino-Laryngological Societies.

Dr. Hao is the founding president of Taiwan Head and Neck Society and Taiwan Oral Cancer Prevention and Therapy Association and the past president of Taiwan Skull Base Society. He is also the founding president and current secretary

general of the Asian Society of Head and Neck Oncology.

Dr. Hao is a reviewer for more than 30 scientific journals and serves on the Editorial Boards of *Otolaryngology–Head and Neck Surgery* and *Laryngoscope*.

➔ **READ MORE ONLINE**
Longer article available

Spotlight: Humanitarian Efforts

Fred L. Daniel, MD

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

I currently practice in Savannah, Georgia. I perform general ENT with a focus on otology and sinus surgery, head and neck, and laryngology, as well as pediatrics.

What humanitarian mission or organization are you involved with?

I work with Faith in Practice, based out of Houston, Texas. This organization is dedicated to the health and well-being of the impoverished in Guatemala, sending surgical and medical teams from all over the United States throughout the year. There is a poor safety net, and our patients would not get the needed surgeries otherwise.

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

My Christian faith led me to the mission field, and after I was invited to go, I have been participating in these mission trips every year since 1999.

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

It can sound like a cliché, but it is true: We who volunteer often get more out of our service than those we serve. It is rewarding to give our talents to those in need, and not worry about payments, insurance, precertification, etc.



Volunteers are always needed.

Check out the website at <https://www.faithinpractice.org/>. ■

➔ READ MORE ONLINE
Longer article available

HUMANITARIAN TRAVEL GRANT

Head and Neck Surgical Care aboard *Africa Mercy*

In February 2020, Allen L. Feng, MD, spent a month aboard *Africa Mercy*, a 500-foot floating hospital and international charity operated by Mercy Ships. *Africa Mercy* represents the largest nongovernment hospital ship in the world, housing over 400 crew members and featuring five operating rooms, an intensive care unit, and beds for up to 82 patients. Crew members serve on a volunteer basis from countries all over the world with a unified goal of treating underserved patients while traveling along Africa's west coast. They treat several conditions, including a wide array of head and neck tumors.

During his time aboard the *Africa Mercy*, Dr. Feng worked alongside Mark G. Shrimme, MD, providing high-quality head and neck surgical care to patients while docked in Dakar, Senegal. They treated patients with a wide array of pathologies—from ameloblastomas to extensive noma defects—and had the



opportunity to share their experience with local surgeons. Patients traveled from all over continental Africa to receive care that they would otherwise be unable to obtain.

"Working with a diverse group of healthcare providers from around the world was a humbling experience. I hope to carry these lessons with me as I continue global surgery efforts throughout my career," said Dr. Feng. ■

➔ READ MORE ONLINE
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POWERED BY AMERICAN ACADEMY OF
OTOLARYNGOLOGY-HEAD AND NECK SURGERY

June Is National Dysphagia Awareness Month

ENThealth.org offers information for your patients on these topics and more:

- Dysphagia
- Aging and Swallowing
- Do I Have a Swallowing Problem?

For more patient information on ENThealth, search under "Conditions and Treatments" and "Be ENT Smart" for articles using keyword "swallowing."

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/>. ■

■ section spotlight



Celebrating Our Teams: The Inaugural WIO He for She Award

Jamie R. Litvack, MD, MS, WIO Chair

L aunched by the United Nations in September 2014, the HeForShe movement is “an invitation for men and people of all genders to stand in solidarity with women to create a bold, visible, and united force for gender equality.”¹ Since its introduction, men from around the world—including heads of state, CEOs, and global luminaries—have pledged to specific, action-oriented goals to advance gender equality.

In celebration of our male colleagues who support and empower women otolaryngologists to achieve their professional goals, the AAO-HNS Women



in Otolaryngology (WIO) Section is pleased to announce the call for nominations for the inaugural He for She Award. This award recognizes a male otolaryngologist who serves as a strong mentor, collaborator, and sponsor of women in otolaryngology. We appreciate and celebrate our male colleagues who openly support and empower women to achieve their professional goals.

The recipient will have the opportunity to accept the award at the WIO meeting at the AAO-HNSF 2021 Annual Meeting & OTO Experience, October 3-6, in Los Angeles, California. Nominees are being sought from all practice types and career stages. Eligibility criteria include any male colleague who advocates for women in otolaryngology; demonstrates support, mentorship, and

sponsorship of women otolaryngologists at all career stages; and is a member in good standing with the AAO-HNS. Please send the nominee's CV in addition to letter(s) of recommendation highlighting examples of the nominee's dedication to sponsoring, supporting, and/or mentoring women otolaryngologists to pgilbert@entnet.org. Nominations are being accepted through July 5. ■

References

1. <https://www.heforshe.org/en/movement>. Accessed April 7, 2021.

WIO General Assembly*

Monday, October 4
Noon - 1:00 pm (PT)

*Schedule subject to change

CONGRATULATIONS

Residents and Fellows

One of the most highly anticipated dates on the academic calendar is June 30. It is a day for great celebration honoring graduating otolaryngology residents and fellows for their years of dedication, perseverance, and sacrifice required to reach their goal and begin the independent practice of medicine in the setting of their choice.

The American Academy of Otolaryngology–Head and Neck Surgery, its officers, Boards of Directors, and staff take great pride in playing a role in the evolution of your careers and offer our heartfelt congratulations to you and your highly committed teachers and families on your great accomplishments. We extend our best wishes for your future. As an organization, we remain committed to meeting your needs as you deliver the best patient care. Now, as always, We Are One.



WE ARE ONE

OTOLARYNGOLOGY UNITED

for ENT Patient Care

pearls from your **peers:** Improving Efficiency in Otolaryngology Practice



INTERVIEWEE

William R. Blythe, MD

*Comprehensive Otolaryngologist and Managing Partner of East Alabama Ear, Nose and Throat, PC, Auburn/Opelika Alabama
Member at Large, AAO-HNS Board of Directors*



INTERVIEWER

Lance A. Manning, MD

Chair, AAO-HNS Board of Governors

This month's Pearls from Your Peers is from the Practice Management Education Committee. We query **William R. Blythe, MD**, regarding tips and best practices for efficiency and productivity in otolaryngology practice. This efficiency helps provide much-needed time for work-life balance and decreases the risk of burnout. Hopefully, it offers more financial security for a practice to hire good staff and allow for investment in technology that helps us best serve our patients.

In your practice, you all have multiple mid-level providers. What do you feel is the best use of mid-level providers to augment and improve otolaryngology care?

Our practice is divided into three teams, each with a physician, an advanced practice provider (APP), and two medical assistants (MAs). The three teams function independently for the most part, and each team utilizes their APP in a slightly different way. Our APPs receive a competitive base salary and production-based bonus, which incentivizes them to be busy. The APP is in the office when the surgeon is in the operating room, so someone is always available to see patients. One APP has a separate schedule

from their supervising doctor, and other physicians utilize a "team" with their APP on a single combined schedule. There is no single right way to do it, but you have to fine-tune the schedules to find the most efficient system. My APP also allowed me to move from seeing 100 patients/week (2.5 days) to seeing 200 patients/week as a team (she sees 20+ patients, five days/week.). That has not only improved our availability for our patients but has reduced wait times, improved patient satisfaction, and increased surgeries. My APP is also my patient coordinator for our cochlear implant and Inspire programs, making her and the patients happy.

What do you feel is the best use of clinical and clerical staff in the office setting to allow them to perform their best?

Personnel management is a constant effort to find just the right balance of just enough of the right people who can work efficiently while taking good care of patients. The most important thing is to hire the right personnel so that they are always functioning at the highest level of their education and training. If you "over hire" and have employees working at the lower end of their capability, you are wasting

both talent and money. Front desk staff and clerical staff must be computer literate and efficient with email and technology, but otherwise do not require higher degrees. We do not employ any registered nurses for our practice, although we have two ACLS-certified nurse practitioners on staff and in the office at all times. We predominantly use MAs for most clinical work. Each of our teams has one MA responsible for directing the patient flow. Ultimately much of the efficiency boils down to how well that MA is coordinating patient flow. The nice thing about having independent teams is that the whole team stays until the last patient is seen. That motivates everyone on the team to keep track of where patients are in the office process and to be efficient. Also, the office manager needs to be a highly trained and well-compensated person who can shoulder the load of human resources and office policies day-to-day without burdening the physicians with those issues.

For more information and Dr. Blythe's list of six practical tips for improving reimbursement efficiency and productivity, read the full interview on the *Bulletin* online. ■

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AAO-HNS/F Annual Secretary-Treasurer Report

Kenneth W. Altman, MD, PhD



As we enter my last budget year as Secretary-Treasurer, I can't help but reflect on initial thoughts coming into this role in 2017 when I was mentored by **Scott P. Stringer, MD**. In addition to his leadership creating fiscal continuity at a time of our Academy's EVP transition, he worked to move away from the complicated accounting required by a credit swap that funded our major real estate holding in Alexandria, Virginia. This left us on firm footing for a fairly routine next four years.

Membership dues and the **Annual Meeting** make up about 75% of the revenue needed to support our operating budget. My initial concerns taking over as Secretary-Treasurer related to generational change and the impact of technology on our future as an organization. Although I've always believed that we're better off as individuals and as a profession with the Academy, I wondered if our recent graduates would have the same loyalties to maintain membership, especially in the face of specialty societies that reflect the growing trend toward niche medicine. With competing economic pressures for clinical performance as a result of rising practice management costs and declining reimbursement, would the attendance at our Annual Meeting still be valued? This is especially compounded by the blurring lines between academics and private practice, with fiscal responsibility applying to both, and a growing number of competing conferences and courses offered despite more limited travel time.

We invested heavily in **Reg-entSM**, which initially rose in 2016 as a response to PQRS reporting requirements for CMS, but it also offered the prospect of aggregate clinical data to define "best care" in otolaryngology, allow clinical research, develop outcomes tools, and serve as a potential source of non-dues revenue. The technology was at its relative infancy at that time, and we were early adopters, allowing us to help drive the future. Another significant change included retiring the 40-year-old Home Study Course in lieu of developing our new **FLEX** (Focused Lifelong Education Xperience) program in 2020 to offer our members cutting-edge education materials available in multiple formats on multiple devices. At the time it was uncertain how quickly this new electronic program would catch on and generate the necessary revenues to maintain the budget.

Last year's budget for FY2021 enjoyed stable membership from the prior year, planning for our Annual Meeting in Boston, growing participation in Reg-ent, and the prospect that our new partnership with OM1 might soon deliver marketing revenue from Reg-ent to support technology and subscriber costs. Then came **COVID-19**.

James C. Denny III, MD, Executive Vice President and CEO, and **Carrie L. Hanlon, CPA**, Senior Director, Finance and Administration, were quick to lead budget changes to include emergency use of net asset reserves in case of a revenue shortfall from the Annual Meeting, among many other initiatives. By the summer of 2020 it was clear the Boston Convention Center would not accommodate a live meeting, but our **Meetings Team**, led by

Coordinators **Mark K. Wax, MD**, and **Daniel C. Chelius, Jr., MD**, were able to quickly pivot to a parallel plan to present our first Virtual Annual Meeting. Aware of the severe financial pressure our members were under, the Academy offered Academy Cares vouchers designed to offset costs for membership renewals (noting no dues increase in the last five years) or any education product. Additionally, we offered bundling of the Annual Meeting registration with FLEX subscriptions to make both more affordable, while promoting both programs.

Despite this tumultuous year, we expect to end the year better than budget neutral without needing to draw from our reserves. Other factors that helped navigate these pressures include projected forgiveness of the stimulus package PPP loans that helped keep staff employed, revenue from the new FLEX product that was more than double budget expectations, and significant projected savings related to travel and staff working from home. We also expect cancellation insurance recovery for the Annual Meeting to match lost revenue, which should put us ahead and enhance our ability to meet next year's budget.

Beyond COVID-19 there will be continuing challenges to membership and Annual Meeting participation. We're fortunate to have shifting demographics to a larger number of younger members, and we will only benefit from new conferencing and education technologies. Our unity, strong sense of purpose, and ability for cutting-edge innovation will guide us in achieving the long-term strategic goals of our Academy to enhance our profession. ■

Proposed Fiscal Year 2022 (FY22) Combined Budget

The Executive Committees (ECs) of the Boards of Directors (BODs) were presented with the Finance and Investment Subcommittee (FISC) proposed budget for the next fiscal year, July 1, 2021-June 30, 2022 (FY22), and endorsed it for approval by the BODs. During their April meeting, the BODs reviewed and conditionally approved the FY22 budget that is presented here to the membership.

Budgeting for FY22 represents the collaborative work of both the staff leadership and the members of the FISC to match stable funding to the mission we aspire to accomplish. The proposed FY22 budget is structured to meet the Strategic Plan goals of the AAO-HNS/F and continue to provide member services in the most effective and efficient way possible.

In early spring, the FISC reviewed financial results for the first six months of the FY21 budget year. Based on this information, it is projected that the FY21 actual results will be within budget.

Highlights of the FY22 Budget

The FY22 balanced budget is proposed at \$19.6M. Operating revenues are budgeted to fund \$16.6M of expenses and Board Designated Net Assets to fund the remaining \$3M. The Board approved the use of net assets to support the higher costs of a hybrid Annual Meeting and potential lower in-person attendance. An offsetting addition to net assets, in an equal or greater amount than budgeted to be used in FY22, is expected from the insurance cancellation

coverage related to the 2020 Annual Meeting. The Board also approved the use of net assets to fund Reg-entSM technology costs, as has been done in past years.

Member dues are not budgeted to increase and remain at the same rate as the last five years. Annual Meeting revenues are budgeted below average to account for the impact of COVID-19 travel restrictions and other related factors. Education and other product sales include an increase in FLEX purchases, which exceeded budget in the prior year. Royalties and advertising revenues continue from publishers of *Otolaryngology–Head and Neck Surgery*, *OTO Open*, and the *Bulletin*. Other revenues include royalties from Academy Advantage partners, the new Corporate Champions program, and donor contributions to the Foundation's Annual Fund. In FY22, revenues related to the Pan American Congress are also included in other revenues. Expenses for this meeting are budgeted in an equal amount such that the net results of the Pan American Congress are budget neutral.

The prior year's budget included a one-time \$1M contingency for the potential impact of the developing coronavirus on Annual Meeting revenues. No similar contingency is budgeted in FY22 since lower Annual Meeting revenues are budgeted to take this into account.

The complete budget is available to any Academy member who requests it in writing. Send email requests to Carrie L. Hanlon, CPA, Senior Director, Finance and Administration, at bulletin@entnet.org. ■

AAO-HNS/F Combined Budgets

	Approved Budget FY21	Proposed Budget FY22
Revenue		
Membership Dues	\$6,950,000	\$6,950,000
Annual Meeting Revenues	7,438,000	5,357,000
Education and Other Product Sales	1,349,000	1,484,000
Publication Revenues	1,210,000	1,217,000
Other Revenues	1,009,000	1,347,000
Use of Donor Restricted Net Assets	262,000	238,000
Operating Revenue	18,218,000	16,593,000
Use of Board Designated Net Assets	1,565,000	3,037,000
Total Revenue	\$19,783,000	\$19,630,000
Expenses		
Salaries & Benefits	\$9,180,000	\$9,329,000
Consultants & Professional Fees	2,236,000	2,083,000
Annual Meeting Costs	3,314,000	3,628,000
Other Expenses	2,618,000	3,189,000
Occupancy	985,000	951,000
Contingencies	1,450,000	450,000
Total Expenses	\$19,783,000	\$19,630,000

Dysphagia in Alzheimer's Disease

Jennifer McLevy-Bazzanella, MD; Melissa M. Mortensen, MD; and Ozlem E. Tulunay-Ugur, MD

Alzheimer's Disease (AD) is a universally fatal, progressive neurocognitive disease. The prevalence of AD is rising, and 6.2 million persons in the United States and 24 million worldwide are effected.¹⁻³ The incidence of AD is expected to double by 2050.¹ AD strikes women more often than men and disproportionately affects Black and Hispanic persons secondary to socioeconomic, environmental, and healthcare disparities.¹ AD currently costs the U.S. \$355 billion per year in healthcare expenses, of which \$76 billion comes directly from the patient and their family.^{1,4} It is the sixth leading cause of death in the U.S.¹ A diagnosis of dysphagia carries a risk of increasing hospital stay length by 40% and may increase costs by \$550 million per year.⁵ Aspiration pneumonia accounts for 6% of AD hospital admissions and is the leading cause of death in AD patients.^{1,2,4}

Dysphagia, even when subclinical, may be present in 50%-75% of early AD patients,³ rising to 84%-93% in moderate-to-severe AD patients.^{2,6} With use of videofluoroscopic swallow study (VFSS), dysphagia may be diagnosed in up to 95% of AD patients.⁶ The primary etiology of AD dysphagia is related to the tau neurofibrillary tangles disrupting the cortical areas of the swallowing system.⁷ The primary cortical areas involved include insula, frontal anterior cingulate cortex, primary and supplementary motor cortex areas, and sensory cortical areas.^{3,8} Somatic-voluntary nervous system involvement impairs oral preparation, oral phase, oral transit, and oropharyngeal stages of swallowing.^{9,10} Meanwhile, autonomic nervous system impairment decreases saliva production as well as pharyngeal and supraglottic sensation, increases residue accumulation, and reduces smooth muscle esophageal motility.⁹⁻¹¹ Risk of penetration and aspiration increases as

AD advances.^{9,10} Cognitive impairment, sarcopenia, postural instability, and central hypotonia also worsen with AD progression.⁶

Dysphagia progresses as severity from subclinical early in AD to overt with moderate AD and eventually to apraxia and tactile-oral agnosia.^{2,3,6-8} With progression of dysphagia from thin liquids to solids (early-to-severe AD), AD patients risk dehydration, malnutrition, aspiration pneumonia, and death.^{2,4,7,11} The significant morbidity and mortality of dysphagia in AD warrants early and frequent assessment while the insidious neurocognitive decline of AD provides significant diagnostic and therapeutic challenges.

Diagnosing Dysphagia in Alzheimer's Disease

As early as the onset of AD, patients may start to have difficulty with swallowing. During the course of the illness, the swallowing function becomes altered in multiple phases. Oral transit time becomes delayed as well as the pharyngeal response—these in conjunction with the decreased ability to recognize food visually, oral-tactile agnosia, swallowing and feeding apraxia result in a hindrance of food intake leading to multiple adverse consequences.¹² It is imperative to detect the initial signs of dysphagia so that patients can be properly managed.

There are three main diagnostic approaches for the assessment of dysphagia in AD. The first is a non-invasive approach with clinical swallow evaluation. The clinical swallow evaluation is an assessment based on both swallowing problem questionnaires completed by the caregiver of the patient and a motor/sensory examination of all oral structures that complete bolus formation and a swallowing evaluation of liquids and solids of different consistencies. The clinical swallow examination is helpful in assessing for oral praxis, improper laryngeal elevation, lack of gag and pharyngeal reflexes, dysphonia, and the patient's swallow attempts.² In addition to the clinical evaluation of swallow,

a comprehensive geriatric assessment (CGA) should be considered. The CGA is a multidisciplinary diagnostic process that identifies medical, psychosocial, and functional limitations in the geriatric population in order to develop a plan that maximizes the patient's health with aging.²

The second approach is to obtain an instrumental assessment, either a VFSS or a fiberoptic endoscopic evaluation of swallowing (FEES). The VFSS helps analyze the bolus preparation, oral transit time, pharyngeal swallow initiation time, hyolaryngeal excursion, laryngeal penetration, and tracheal aspiration.⁹ Several studies demonstrate that mild, moderate, and severe AD have significant findings on VFSS, typically starting with prolonged oral transit time and escalating to frank aspiration.^{1,12,13} FEES is less commonly instituted to examine AD patients. This may be secondary to decreased cognitive ability and compliance with the flexible laryngoscopy. In the only study using FEES to assess dysphagia in AD patients, the authors reported that the patients who were not orientated were at a higher risk of aspiration than those patients who were.¹⁴

When there is a cognitive or communication issue with an AD patient, VFSS and FEES may be difficult to employ. There is a growing body of literature about the development of non-invasive electrophysiological swallow tests.^{3,15,16} The dysphagia limit (DL) test combines electrophysiologic monitoring of the submental/suprahoid areas with consecutively increasing volumes of water given to the patient. A normal DL is more than 20 ml. DL was noted to be significantly reduced in patients with AD—45% of AD patients with mild disease, 85% with moderate disease, and 89% with severe disease were found to have abnormal DL. This demonstrates that dysphagia can develop early in the disease process and become progressively worse as the disease evolves.

Management of Dysphagia in Alzheimer's Disease

As mentioned, dysphagia has significant consequences due to malnutrition, weight loss, dehydration, and aspiration pneumonia leading to lengthy hospital stays and mortality. The main goal is avoidance of these complications while maintaining the quality of life of the patient. Of utmost importance is to discuss long-term goals with patients when their cognitive status allows them to make informed decisions and they are able to express their wishes about invasive measures, such as feeding tube placement. Unfortunately, as otolaryngologists, we are generally consulted at late stages of the disease, frequently when patients cannot make these decisions and we have to rely on input from caregivers. As we will continue to see increasing numbers of patients with AD in our clinics, two very useful resources include a systematic review by Alagiakrishnan et al., discussing oropharyngeal dysphagia evaluation and management in various types of dementia, and the review paper by Goldberg et al. Reporting that feeding tube placement largely happens when there is an acute hospitalization due to pneumonia or weight loss, these papers review the outcomes of enteral feeding in detail.^{17,18} Kuo et al., evaluating the incidence of feeding tube insertions in nursing home residents, report an overall one-year mortality rate of 64.1% with a median survival of 56 days post insertion of tube. Furthermore, 20% of these patients require a transfer back to hospital for tube-related complications.¹⁹ Similar outcomes are reported by other studies showing 58% of enterally-fed nursing home patients with dementia suffer from aspiration pneumonia as compared to 16% of those fed orally.²⁰ Multiple studies corroborate these findings and point clearly to the detriment of feeding tube insertion. While there is no survival benefit with its insertion, the 30-day and 12-month mortality rates are higher compared to patients who do not receive

feeding tubes.²¹⁻²³ When counseling patients, the above findings are important to note, including the fact that feeding tubes do not prevent aspiration pneumonia.

As otolaryngologists, most of our efforts will focus on diet modification, postural modifications, and swallowing therapy. Possibly one of the most important components of the initial evaluation is the assessment of polypharmacy. Medications that result in xerostomia, sedation, or cognitive decline should be discontinued if possible. Diet modifications are made depending on VFSS results, and during the earlier stages of the disease, swallowing therapy can be employed successfully. Tang et al. have shown that neuromuscular electrical stimulation and electromyographic feedback can be successful in improving dysphagia in AD patients.²⁴

In conclusion, Alzheimer's Disease is a complicated, progressive neurological disease that is now one of the leading causes of death in the U.S. Due to the increasing prevalence, we need to equip ourselves with evidence-based knowledge to be able to guide patients and families through many difficult medical, ethical, and moral decisions. ■

References

- 2021 Alzheimer's disease facts and figures. *Alzheimers Dement*. 2021 Mar;17:327-406.
- Boccardi V, Ruggiero C, Patriti A, et al. Diagnostic assessment and management of dysphagia in patients with Alzheimer's disease. *J Alzheimers Dis*. 2016;50:947-955.
- Seçil Y, Arıcı Ş, İncesu TK, et al. Dysphagia in Alzheimer's disease. *Neurophysiol Clin*. 2016;46:171-178.
- Tian H, Abouzaid S, Sabbagh MN, et al. Health care utilization and costs among patients with AD with and without dysphagia. *Alzheimer Dis Assoc Disord*. 2013;27:138-144.
- Altman KW, Yu GP, Schaefer SD. Consequence of dysphagia in the hospitalized patient: impact on prognosis and hospital resources. *Arch Otolaryngol Head Neck Surg*. 2010;136:784-789.
- Özsürekli C, Arslan SS, Demir N, et al. Timing of dysphagia screening in Alzheimer's dementia. *JPEN J Parenter Enteral Nutr*. 2020;44:5165-24.
- Douglas VC, Josephson SA. Dementia and Systemic Disease. In: Aminoff MJ and Josephson SA, ed. *Aminoff's Neurology and General Medicine*, 6th ed. Cambridge, MA: Academic Press of Elsevier; 2021: 1099-1110.
- Humbert IA, McLaren DG, Kosmatka K, et al. Early deficits in cortical control of swallowing in Alzheimer's disease. *J Alzheimers Dis*. 2010;19:1185-1197.
- Affoo RH, Foley N, Rosenbek J, et al. Swallowing dysfunction and autonomic nervous system dysfunction in Alzheimer's disease: a scoping review of the evidence. *J Am Geriatr Soc*. 2013;61:2203-2213.
- Mehraban-Far S, Alrassi J, Patel R, et al. Dysphagia in the elderly population: a videofluoroscopic study. *Am J Otolaryngol*. 2021;42:102854.
- Nawaz S, Tulunay-Ugur OE. Dysphagia in the older patient. *Otolaryngol Clin North Am*. 2018;51(4):769-777.
- Priefer BA, Robbins J. Eating changes in mild stage Alzheimer's disease. A pilot study. *Dysphagia* 1997;12:212-221.
- Horner J, Alberts MJ, Dawson DV, Cook GM. Swallowing in Alzheimer's disease. *Alzheimer Dis Assoc Disord* 1994;8:177-189.
- Leder SB, Suiter DM, Lisitano Warner H. Answering orientation questions and following single step verbal commands: effects on aspiration status. *Dysphagia* 2009;24:290-295.
- Ertekin C, Aydogdu I, Yuceyar N. Piecemeal deglutition and dysphagia limit in normal subjects and in patients with swallowing disorders. *J Neurol Neurosurg Psychiatry* 1996;61:491-496.
- Gürgör N, Arıcı Ş, İncesu TK, et al. Am electrophysiological study of the sequential water swallowing. *J Electromyogr Kinesiol* 2013;23:619-626.
- Alagiakrishnan K, Bhanji RA, Kurian M. Evaluation and management of oropharyngeal dysphagia in different types of dementia: a systematic review. *Arch Gerontol Geriatr* 2013;56:1-9.
- Goldberg LS, Altman KW. The role of gastrostomy tube placement in advanced dementia with dysphagia: a critical review *Clin Interv Aging* 2014;9:1733-1739.
- Kuo S, Rhodes RL, Mitchell SL, et al. Natural history of feeding-tube use in nursing home residents with advanced dementia. *J Am Med Dir Assoc* 2009;10:264-70.
- Peck A, Cohen CE, Mulvihill MN. Long-term enteral feeding of aged demented nursing home patients. *J Am Geriatr Soc*. 1990;38:1195-1198.
- Sanders DS, Carter MJ, D'Silva J, et al. Survival analysis in percutaneous endoscopic gastrostomy feeding: a worse outcome in patients with dementia. *Am J Gastroenterol*. 2000;95:1472-1475.
- Mitchell SL, Kiely DK, Lipsitz L. The risk factors and impact on survival of feeding tube placement in nursing home residents with severe cognitive impairment. *Arch Int Med*. 1997;157:327-332.
- Nair S, Hertan H, Pitchumoni CS. Hypoalbuminemia is a poor predictor of survival after percutaneous endoscopic gastrostomy in elderly patients with dementia. *Am J Gastroenterol*. 2000;95:133-136.
- Tang Y, Lin X, Lin XJ, et al. Therapeutic efficacy of neuromuscular electrical stimulation and electromyographic biofeedback on Alzheimer's disease patients with dysphagia *Medicine* (Baltimore). 2017;96:e8008.



RUC Surveys: A Critical Component of Determining Medicare Reimbursement

R. Peter Manes, MD, Coordinator for Advocacy and AAO-HNS RUC Advisor

The Current Procedural Terminology (CPT) Editorial Panel creates new Category I CPT codes. This process occurs when a new procedure or device is introduced and there is not yet an existing code in the current CPT code-set to accurately describe the new service. New codes often replace the use of a temporary Category III code and result in streamlined reimbursement for providers. While the creation of new Category I CPT codes is an important first step in the process of adopting new services and advancing technology, this is not where the path to adoption ends.

After a code is created by the CPT Editorial Panel, the code is then sent to the RVS Update Committee (RUC) Panel for valuation. This valuation is based on evidence provided by medical societies and includes malpractice, practice expense (PE), and work Relative Value Units (RVUs). Previously established codes may also be included in the valuation survey process. The resurvey of an established code can occur for a variety of reasons, including by request from the Centers for Medicare & Medicaid Services or due to large changes in utilization.

Although the malpractice and PE RVUs are important, this article will focus on the development of work RVUs. The work RVUs for otolaryngology codes are determined according to surveys completed by Academy members. These surveys must be performed either when new codes affecting the specialty are created, or when existing codes are edited beyond simple semantics.

RUC surveys are created according to a template provided by the American Medical Association (AMA) and utilize existing standardized questions. This standardized process allows for the RUC Panel to review

recommendations across all specialties equally. Survey questions include how long a procedure takes as well as intensity comparisons to currently valued codes. The AMA requires a minimum number of surveys to be completed in order for the results to be considered valid. If the minimum is not realized, the process must be repeated. Achieving a higher number of surveys is preferable as accuracy can increase with a larger dataset.

When RUC surveys are sent out, they are not distributed to the entire AAO-HNS membership. Instead, surveys are sent to a carefully selected group of Academy members. The selection of potential survey respondents is made based on the procedure performed and subspecialty designation. For example, if the procedure being valued is typically done by laryngologists, a random selection of Academy members who self-designate as laryngologists will receive the survey. The Academy also works with the various otolaryngology subspecialty organizations to ensure that appropriate representation from these groups' membership is also included in the survey results. As with any survey process, the Academy and AMA/RUC expect that there will be some variation in survey responses. Mechanisms are built-in to account for survey outliers, however an accurate capturing of current standards of care is paramount in attaining appropriate value for the procedure from the survey. Therefore, all survey input is taken into consideration.

After surveys are returned, the RUC panel convenes to begin valuation according to the responses received. The RUC Panel is required to value procedures as the code change applications have already been passed by the CPT Editorial Panel but is not required to accept the survey results. If the panel determines that survey responses are invalid, the survey process must be repeated and the process begins again.

RUC surveys are a crucial part of the Medicare valuation process, on which many third-party payers also base reimbursements.

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As such, the Academy implores members who receive a RUC survey and have experience in performing the procedure under review to contribute to the process by carefully and thoroughly completing the survey. At the same time, the Academy also requests AAO-HNS members to consider the potential impact of skewed survey results in the event they receive a survey for a procedure that they do not often perform.

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As such, the Academy implores members who receive a RUC survey and have experience in performing the procedure under review to contribute to the process by carefully and thoroughly completing the survey. At the same time, the Academy also requests AAO-HNS members to consider the potential impact of skewed survey results in the event they receive a survey for a procedure that they do not often perform. The Academy encourages practitioners to complete the surveys as accurately and thoroughly as possible.

The AAO-HNS greatly values the contributions made by members through the RUC survey process, as it would not be possible without member participation. These contributions are an essential component of the RUC process and help ensure that otolaryngologist-head and neck surgeons are reimbursed accurately, fairly, and effectively for the important services they provide. ■



AAO-HNS/F 2021 Leadership Forum & BOG Spring Meeting Advocacy Program

The Academy's Board of Governors (BOG), led by Chair **Lance A. Manning, MD**, hosted its first virtual AAO-HNS/F Leadership Forum & BOG Spring Meeting on April 17. Hundreds of Academy members came together to participate in a diverse advocacy-focused program. The event provided an opportunity for leadership discussions and sharing of practice management tools for seasoned AAO-HNS member advocates, young physicians, residents, and others looking to become more involved in the BOG and Academy advocacy efforts. The day consisted of interactive sessions led by BOG leaders and subject-matter experts.

The event featured federal health policy and legislative updates from Congressional guests including, Congressman Larry Bucshon, MD (R-IN), and Wendell Primus, PhD, Senior Policy Advisor on Budget and Health to Speaker Nancy Pelosi (D-CA); a keynote address from Susan Bailey, MD, President of the American Medical Association; and a presentation on Reimbursement Advocacy and 2021 Coding Updates by AAO-HNS Advocacy Coordinator, **R. Peter Manes, MD**. AAO-HNS Congressional Advocacy staff spoke to participants about the Academy's 2021 federal legislative and regulatory priorities, including:

- Working with our champions in Congress to improve the Medicare physician payment system by providing an inflationary payment update, revisiting budget-neutrality requirements, and maintaining the 10- and 90-day global surgery payment package
- Protecting patient safety by fighting scope-of-practice efforts by certain advanced practice providers, including audiologists—ensuring audiologists are not granted inappropriate access to Medicare patients without a physician referral
- Streamlining and standardizing insurers' increased use of prior authorization
- Advocating for a restructuring of Medicare's quality improvement program to minimize its complexity, streamline and reduce reporting burdens, and promote specialty-specific quality measures, clinical data registries, and alternative payment models developed by clinicians

The Academy is actively advocating on these important issues in the 117th Congress to protect the specialty and the patients our members treat.

We thank the AAO-HNS/F 2021 Leadership Forum & BOG Spring Meeting attendees for collective efforts to advance the Academy's 2021 advocacy priorities and programs. We stand ready to work with our members to promote this comprehensive agenda and look forward to continuing these critical advocacy discussions in person in Los Angeles, California, at the AAO-HNSF 2021 Annual Meeting & OTO Experience in October. Please email the AAO-HNS Legislative Advocacy team at govtaffairs@entnet.org with questions or suggestions. ■

STATE LEGISLATIVE ALERT

Children Require a Medical Evaluation before Hearing Aid Purchase

AAO-HNS members are committed to the highest standards of otolaryngologic care for their pediatric patients, which includes advocating to ensure that the medical diagnosis and care children receive is provided by the best trained professional for their medical disorders.

Most state legislators are unaware that the Food and Drug Administration (FDA) regulates hearing aids as medical devices. The FDA's requirements at 21CFR801.420 fully support the requirement for a medical evaluation by a qualified physician prior to dispensing a hearing aid. In the section labeled Important Notice for Prospective Hearing Aid Users, the FDA states: *"Good health practice requires that a person with a hearing loss have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. Licensed physicians who specialize in diseases of the ear are often referred to as otolaryngologists, otologists or otorhinolaryngologists. The purpose of the medical evaluation is to assure that all medically treatable conditions that may affect hearing are identified and treated before the hearing aid is purchased."* Part of this regulation goes on to require a waiver if an individual did not have a medical evaluation within six months of the purchase of a hearing aid. In 2016, the FDA issued guidance that, while still recommending the waiver/medical exam requirement **for adults**, it would no longer enforce it. The agency made it very clear, however, that **for children, the physician/medical evaluation still stands**: *"Due to the specific needs and health concerns associated with children with hearing loss, we believe that the medical evaluation requirement should continue to be enforced for all prospective hearing aid users younger than 18 years of age."*

The Academy, its State Trackers, and state advocates remain dedicated to sharing these important facts with state legislators through testimony, letters of concern, and requested legislative amendments. Every year, approximately 20 states file insurance coverage bills for hearing aids. This year, despite the ongoing pandemic and its impact on our public health systems, has been no exception. Armed with the facts, the Academy and its dedicated Advocacy Network steadfastly advocates to successfully amend hearing health state legislation to safeguard the best interests of children and their families. ■

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Private Payer Advocacy Spotlight: Wins and Recent Actions

The AAO-HNS is actively engaged in private payer advocacy efforts to maximize coverage and reimbursement of procedures provided by our members to increase the health and well-being of their patients. Advocacy staff continually monitor private payer policy decisions and, as necessary, work with individual insurers when a policy is issued that would be detrimental to practicing otolaryngologist-head and neck surgeons.

Throughout the past year, the Academy has been active on several private payer coverage and reimbursement issues. Much of the Health Policy Advocacy team's efforts have related to coverage issues surrounding surgical treatment of obstructive sleep apnea, imaging requirements for sinus surgeries, balloon dilation for treatment of chronic rhinosinusitis, and balloon dilation of the eustachian tube. Additionally, following an extensive review process by multiple AAO-HNS Committees and the Physician Payment Policy (3P) Workgroup, the AAO-HNS submitted responses to two Blue Cross Blue Shield Association's (BCBSA) Evidence Street evidence summaries: Balloon Dilation of the Eustachian Tube and Surgical Treatment of Snoring and Obstructive Sleep Apnea. By providing clinical input on these evidentiary summaries, the AAO-HNS has an opportunity to directly impact the clinical input that is assessed by BCBSA to inform future medical coverage policies by Blue Cross plans.

Obstructive Sleep Apnea Treatment

In June 2020, the AAO-HNS sent comments to Cigna opposing their medical policy on "Obstructive Sleep Apnea Treatment Services," which designated hypoglossal nerve stimulation (HGNS) as investigational. Based on coverage by all the Medicare Administrative Contractors, other private insurers, and strong evidence demonstrating HGNS's efficacy, the Academy

requested that Cigna amend its policy to include coverage of this procedure. In response to the Academy's submission, Cigna updated its policy to include coverage of HGNS when specific clinical criteria are met.

Balloon Sinus Ostial Dilation for Treatment of Chronic Rhinosinusitis (BSOD)

In July 2020, following the Academy's advocacy efforts and submission of clinical input, the Blue Cross Blue Shield Federal Employee Program updated its medical policy on "Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis." The procedure is now considered medically necessary for the treatment of chronic rhinosinusitis when specific criteria are met.

Similarly in October 2020, following extensive advocacy efforts by the AAO-HNS, the Iowa Academy of Otolaryngology, and other stakeholders, Wellmark revised its medical policy "Functional Endoscopic Dilation of the Sinuses and Sinus Implantable Devices." Wellmark, which operates commercial insurance plans in Iowa and South Dakota, now includes coverage of balloon ostial dilation for chronic rhinosinusitis in adults when specific clinical criteria are met. Wellmark previously deemed the procedure investigational for this patient population.

Image Upload Requirement for FESS and BSOD

In December 2020, following Academy review and input, UnitedHealthcare (UHC) amended its proposed medical policies on "Functional Endoscopic Sinus Surgeries (FESS) and BSOD." The proposed policies contained an onerous requirement that mandated the uploading of CT images for every patient undergoing FESS or BSOD. The Academy strongly disagreed with this mandatory submission requirement and

Members experiencing coverage and reimbursement denials are encouraged to reach out to the Academy's Health Policy Advocacy staff at healthpolicy@entnet.org.

highlighted significant concerns regarding the utility, interpretation, and labeling of individual patient's CT scans. In response to the Academy's policy review, the final FESS and BSOD medical policies (effective February 1, 2021) were amended to state that the CT images are not required in all cases but, for certain patients, may be requested.

Balloon Dilation of the Eustachian Tube

Throughout 2020 and 2021, the Academy has been engaging in advocacy efforts with Cigna to reverse the insurer's negative coverage policy on balloon dilation of the eustachian tube. In April 2021, in response to these efforts, Cigna revised its "Balloon Sinus Ostial Dilation for Chronic Sinusitis and Eustachian Tube Dilation" medical coverage policy to state that unilateral or bilateral eustachian tube balloon dilation is considered medically necessary once per lifetime for the treatment of chronic obstructive eustachian tube dysfunction.

Members experiencing inappropriate coverage and reimbursement denials are encouraged to reach out to the Academy's Health Policy Advocacy staff at healthpolicy@entnet.org with the relevant medical policy and denial letter(s). ■



Deploying Grassroots Advocates in a Virtual Environment


The COVID-19 pandemic has impacted nearly every aspect of life for AAO-HNS members, including how they engage in critical advocacy activities. After life as we knew it was halted in mid-March 2020, the business of advocacy remained at the forefront. As our nation's physicians were called to the frontlines of the public health emergency to treat their patients in the face of an unknown enemy, while protecting themselves and their families, the need for the federal government to provide support for the practice of medicine was more urgent than ever.

At the onset of the pandemic, U.S. Senators, Representatives, and Congressional staff halted in-person meetings, shifting to a fully virtual lobbying environment. This led to an

immediate increase in use of platforms such as Zoom and a renewed focus on advocacy contact through phone calls, emails, and letters. The Academy increasingly relied upon its established grassroots programs, including Project 535, which links an otolaryngologist to each of the 535 members of Congress, and I-GO, the In-District Grassroots Outreach program. These initiatives allowed AAO-HNS members to continue to advocate for their practices and patients and to bolster the voice of the specialty before Congress.

Over the course of the past year, AAO-HNS grassroots advocates sent over 1,500 letters through email to Senators and Representatives advocating for COVID-19 relief, Medicare sequestration reprieve, surprise billing remedies, and increased physician liability protections. Thanks to the virtual grassroots efforts of the AAO-HNS Advocacy Network, Academy members were able to celebrate many legislative successes at the close of the 116th Congress. Now that a new Congress has begun, the AAO-HNS is working with our Congressional champions to shape the legislative agenda. Concurrently, we are actively monitoring opportunities for Academy members to engage with members of Congress. These collective efforts help to ensure otolaryngologist-head and neck surgeons, their patients, and practices are protected during the ongoing Congressional debate on healthcare reform.

The Academy's Advocacy team stands ready to help our members raise their voices, whether in person or through a virtual platform. Please contact govtaffairs@entnet.org to sign up for the ENT Advocacy Network or share any questions. The Academy appreciates our current ENT Advocacy Network members' efforts and looks forward to future members joining the ranks to strengthen our specialty's collective voice! ■



PROJECT 535

Become a Member of Project 535

Successful legislative advocacy starts with a solid grassroots foundation. Our goal is to recruit a key contact for each U.S. Senate and House Congressional seat to strengthen outreach to federal legislators when major healthcare issues are debated by Congress. There are still a number of states and districts where we need coverage. The commitment is minimal, but the impact is immense. Sign up today to join this exciting program! Please contact us at govtaffairs@entnet.org to sign up for Project 535 or ask any questions. The Academy appreciates the efforts of our current Project 535 volunteers and looks forward to future members joining the ranks and strengthening our collective voice!

ENT PAC

Thank You to the 2021 ENT PAC First 50

ENT PAC, the political action committee of the AAO-HNS, is a nonpartisan, issue-driven entity that supplements the Academy's legislative advocacy efforts and helps to increase the visibility of the specialty on Capitol Hill and with key policymakers. The ENT PAC Board of Advisors and staff are grateful for the 50 contributors who committed at least \$1,000 to ENT PAC through the "First 50" campaign.

The First 50 campaign helps ensure the Academy can actively engage on issues critical to the specialty. First 50 contributors receive exclusive access to a 2021 conference call series with high-ranking individuals from Congress or the Administration. If you have questions or would like additional information, please contact ENT PAC staff at entpac@entnet.org.

The Academy would like to thank the following 2021 First 50 contributors for their dedication and financial support of the advocacy efforts on behalf of the specialty:

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FROM THE EDUCATION COMMITTEES

Sleep Apnea Surgery in the Elderly

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

The population of elderly adults in the United States is the fastest growing subset and is expected to double by the year 2030. The prevalence of obstructive sleep apnea (OSA) is higher in older adults compared to middle-aged adults, likely due to changes in both structure and physiology associated with normal aging.¹ Anatomical changes include an increase in soft palatal length, increase in length of the airway, and enlargement of the parapharyngeal fat pads, all of which have been associated with the development of OSA. Additional changes in the facial skeleton include a loss of mandibular bone resulting in a decrease in vertical dimension of the oral cavity and thereby less space for the tongue. Changes in respiratory and sleep physiology also occur with the natural aging process favoring increased collapsibility of the upper airway.²

Sleep apnea surgery is being performed at an increasing rate as new techniques and procedures have been introduced during the past two decades. There has also been a reported increase in the proportion of elderly patients undergoing sleep apnea surgery, which leads to questions regarding the efficacy and safety of such surgery in this patient population.³

There are two general categories of surgery for the treatment of OSA: (1) structural surgery and (2) upper airway stimulation (UAS), also known as hypoglossal nerve stimulation. The purpose of structural surgery is to alter a patient's anatomy in order to

increase the dimensions of the upper airway. The purpose of UAS is to increase muscle tone during sleep to minimize upper airway obstruction.

Previous reports have revealed worse outcomes with traditional structural surgery in older adults compared to younger adults. This difference in surgical outcome for both single-level and multi-level structural surgery is believed to be due, in part, to the loss of upper airway muscular tone associated with increasing age. In addition, elderly patients appear to be at increased risk of post-operative complications following sleep apnea surgery.⁴

Over the past 30 years, numerous structural surgeries have been developed to enlarge the upper airway but have failed to address the underlying loss of muscle tone associated with sleep onset, which is pivotal to the pathogenesis of OSA. In contrast, UAS was designed to increase upper airway muscle tone during sleep, thereby alleviating obstructive events.

The Adherence and Outcome of Upper Airway Stimulation for OSA International Registry (ADHERE) represents a collection of retrospective and prospective outcome measures across multiple institutions in the United States and Europe and is currently the largest cohort of patients using UAS. A recent study published from the registry examined the effect of age on UAS outcomes.⁵ Comparing surgical results from patients > 65 years of age to younger patients, this study revealed that both age groups had a significant reduction in AHI following UAS implantation.

However, older individuals had a greater reduction in AHI compared to younger patients (final postoperative AHI of 7.6 vs.

11.9 respectively, $p=.01$). Importantly, no major adverse events were reported for either age group. As previously noted, the elderly have a greater propensity for upper airway collapse as well as a reduction in ventilatory demand. These factors may help to account for the greater improvement in sleep apnea severity observed in the elderly compared to younger adults and suggest that UAS may be a preferred treatment option in this patient population.

With a growing population of elderly patients in the U.S. seeking treatment for OSA, age is becoming an increasingly important consideration for sleep surgeons. Recent reports indicate that traditional structural surgery for elderly patients may be less effective and that postoperative complication rates are higher. In contrast, early reports on UAS therapy suggest improved efficacy with increasing age without an increase in postoperative morbidity. Although advanced age itself is not a contraindication for surgery, the balance of risks versus benefits should be carefully weighed in the elderly patient population. ■

References

1. Young T. Predictors of Sleep-Disordered Breathing in community-dwelling Adults: The Sleep Heart Health Study. *Arch Intern Med.* 2002;162:893-900.
2. Edwards BA. Obstructive sleep apnea in older adults is a distinctly different physiologic phenotype. *Sleep.* 2014;37:1227-1236.
3. Ishman SL. Temporal trends in sleep apnea surgery: 1993-2010. *Laryngoscope.* 2014;124:1251-1258.
4. Gouveia C. Sleep surgery in the elderly: lessons from the national surgical quality improvement program. *Otolaryngol Head and Neck Surg.* 2017;156(4):757-764.
5. Withrow K. Upper airway stimulation response in older adults with moderate to severe obstructive sleep apnea. *Otolaryngol Head and Neck Surg.* 2019;16(4):714-719.

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

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

Across all indications, the incidence of treatment-emergent eosinophilia (≥500 cells/mcL) was similar in DUXIPENT and placebo groups. Treatment-emergent eosinophilia (≥5,000 cells/mcL) 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.

Regardless of age or population, ~2% to 4% of subjects in placebo groups were positive for antibodies to DUXIPENT; ~2% exhibited persistent ADA responses, and ~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 adult subjects who experienced high titer antibody responses developed serum sickness or serum sickness-like reactions during DUXIPENT therapy [see *Warnings and Precautions* (5.1)].

6.3 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of DUPIXENT. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Skin and subcutaneous tissue disorders: Facial Rash

7 DRUG INTERACTIONS

7.1 Live Vaccines

Avoid use of live vaccines in patients treated with DUPIXENT.

7.2 Non-Live Vaccines

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

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Exposure Registry

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

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

Risk Summary

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

Data

Animal Data

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

8.2 Lactation

Risk Summary

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

8.4 Pediatric Use

CRSwNP

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

8.5 Geriatric Use

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

10 OVERDOSE

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

17 PATIENT COUNSELING INFORMATION

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

Pregnancy Registry

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

Administration Instructions

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

Hypersensitivity

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

Conjunctivitis and Keratitis

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

Eosinophilic Conditions

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

Reduction in Corticosteroid Dosage

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

Patients with Comorbid Asthma

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



REGISTRATION WILL OPEN **JUNE 21**

Join us in Los Angeles, California
October 3-6, for the 125th Anniversary

- ★ Conference registration includes one-year access to OTO Logic with the opportunity to earn 300+ hours of CME credit
- ★ Introduction of the New 'Personal and Professional Development' specialty track
- ★ New features include the Great Debates, Simulation Activities, and ENTrepreneur Faceoff
- ★ **SATURDAY, OCTOBER 2, 6:00 PM (PT), AT XBOX PLAZA**
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- ★ **MONDAY, OCTOBER 4, AT CEDARS-SINAI**
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MORE INFORMATION TO COME

www.entannualmeeting.org



125 Year Celebration at the AAO-HNSF 2021 Annual Meeting & OTO Experience

Registration Opens June 21

James C. Denny III, MD

AAO-HNSF Executive Vice President and CEO

Uniting the specialty as one has always been the point of the Annual Meeting, even from its conception back in 1896 when **Hal Foster, MD**, sent more than 500 invitations to southern and western U.S. physicians engaged in ophthalmology and otolaryngology. It was that action by one person and then those who responded that set in motion a rich and robust history of the annual gathering of the AAO-HNSF.

Throughout our history, various challenges have presented themselves to try and prevent our annual gathering. It is amazing that in 125 years there is only one year in which a meeting did not occur. In 1945, for what should have been the 50th meeting, the needs of country took priority as directives from the Office of Defense Transportation to reserve hotel rooms, bus seats, and plane seats for military personnel in the later days of World War II redeployment caused its cancellation. Considering the response to our first Virtual Annual Meeting in 2020, there is no doubt that if the technology was available back in 1945, it is very likely that the annual gathering of otolaryngology minds would have still occurred.

Throughout history, the Annual Meeting has always been a treasured experience as each generation of otolaryngologist-head and neck surgeons forge their path in the specialty and engage with their Academy. The perseverance to meet and connect in an atmosphere that cultivates an invigorating and innovative scientific program is at the core of what the Annual Meeting means to this specialty and those who participate.

The Annual Meetings equate to memories

that are engrained in individuals' journeys as otolaryngologist-head and neck surgeons. There is no doubt that those who have attended in years past have defining milestone moments in their professional careers that were shaped at the Annual Meeting. And for those who have their first Annual Meeting on the horizon, yours are yet to come.

The Annual Meeting provides this unique space—a shared environment where there is a common bond of understanding of the challenges, opportunities, complexities, joys, and heartache that comes with patient care of the intricate ear, nose, throat, and head and neck.

The AAO-HNSF leadership and Annual Meeting Program Committee have developed a 2021 program that not only engages you in an innovative and cutting-edge education program but also presents our global otolaryngology community with the opportunity to connect in ways that we have missed for more than a year.

The following pages give you just a glimpse at some of the programming with the keynote speaker, honorary guest lecturers, and AAO-HNSF EVP and CEO special sessions. As there is so much more in store for our 125th Anniversary, stay up to date with the latest information and programming details by bookmarking <https://www.entannualmeeting.org/>.

I am truly excited about our upcoming meeting in Los Angeles! We are celebrating our organization's 125th anniversary with an innovative program, a specialty-wide Presidents' Reception held at Xbox Plaza and hosted by AAO-HNSF President **Carol R. Bradford, MD, MS**, honoring current and Past Presidents of all specialty societies, and most of all, a chance for personal interaction with new and old friends for the first time in two years.

The event that I am anticipating the most is the inaugural ENTpreneur Faceoff.



Calling All Inventors and Innovators

The call for submissions for the inaugural innovation ENTpreneur Faceoff is open now through July 5.

This new event provides a platform for those involved in digital health, medical device, diagnostic, or drug innovation, to present your ideas, projects, or start-ups.

The top teams will be invited to present at the meeting and compete for awards on the evening of Tuesday, October 5, 6:00 – 8:00 pm (PT).

Learn more at www.entannualmeeting.org/2021-call-for-science/.

Throughout the history of our specialty and organization, we have been blessed with a series of new devices, treatments, and innovations that have expanded and advanced our specialty and organization. Currently, we are all benefitting from new technologies in the otolaryngology space and this competition, facilitated by the support of the Medical Devices and Drugs Committee, will feature the best and brightest inventors in our specialty "facing-off" against each other in a friendly competition with a "Shark Tank" type format in front of a live audience that includes potential partners and investors followed by a reception. We could be previewing the next generation of care-improving products allowing us to take better care of patients. This promises to be a highlight of this year's meeting and a mainstay event at future Annual Meetings. I look forward to seeing you all at this groundbreaking event. ■

#OTOMTG125 to Feature Neha Sangwan, MD, as Keynote Speaker

The AAO-HNSF is honored to welcome Neha Sangwan, MD, as the AAO-HNSF 2021 Annual Meeting & OTO Experience keynote speaker. As the specialty comes together to celebrate our 125th anniversary, Dr. Sangwan will provide a positive outlook on wellness for the medical community both as a whole and as individuals.

Otolaryngologist-head and neck surgeons are trained to put the patient first, leading to decades of behaviors placing the needs of oneself on the back burner. This was no truer than during the heights of the ongoing pandemic. The AAO-HNSF is setting the tone for the 2021 Annual Meeting by affording attendees access to the expertise of a presenter like Dr. Sangwan, providing the knowledge, tools, and inspiration for self-reflection, self-care, well-being, and resilience.

About Dr. Sangwan

Dr. Sangwan's style is informative, experiential, and inspiring. A gifted speaker, she uses storytelling from her experiences in both the corporate world and on the front lines of patient care to spark breakthrough experiences for others.

Both a physician and engineer by training, Dr. Sangwan is CEO and founder of Intuitive Intelligence, a leadership consulting firm. Through combining the science of medicine with the art of communication, her innovative program, the i-Five Experience™, uses scientifically proven techniques to reduce stress, build resilience, and foster individual and team accountability. An internal medicine physician who has discovered the prescription for inspiring transformation in leaders and teams, Dr. Sangwan's keynote

will provide practical tools that elevate self-awareness and connect the dots between health and leadership performance.



She works with innovative companies such as Apple, Google, and American Express and also partners with healthcare institutions and universities such as Kaiser Permanente, Harvard's Brigham & Women's Hospital, Stanford University, and University of Michigan. Dr. Sangwan has pioneered programs that measurably improve metrics related to culture transformation, employee engagement, productivity, provider-patient communication, and client satisfaction. She has shared her learnings on multiple TEDx stages and also as the author of *Talk Rx: Five Steps to Honest Conversations that Create Connection, Health, and Happiness*.

After earning her BS in mechanical and biomedical engineering at Michigan State University, she worked as a manufacturing engineer at Motorola before attending medical school at State University of New York at Buffalo. She went on to complete her internal medicine residency at Temple University, where she practiced as a hospitalist and became a physician-partner at Kaiser Permanente in Northern California. Dr. Sangwan discovered the connections between health and productivity as she explored the root causes of her hospitalized patients' ailments. Dr. Sangwan is faculty for the Center for Mind Body Medicine and is also nationally certified by the International Federation of Coaches (ICF). ■

"It is well recognized that the complexities and stress of the healthcare environment can compromise the well-being of the workforce. Further, we, as clinicians, are subject to increasingly time-consuming administrative activities. It can, at times, be more difficult to maintain a healthy work-life integration. Burnout and other mental and physical health concerns can be a direct result of these challenges.

One of my primary initiatives as your President is to focus on how to foster the wellness of our community. The pandemic has resulted in tremendous social isolation as well as financial challenges. Further, COVID-19 has highlighted health disparities within our society. Many people, including our patients, are experiencing increased fear and anxiety. **Never has a clearer focus on the importance of wellness been more important.**"

– Carol R. Bradford, MD, MS, AAO-HNS/F President, November 2020 *Bulletin* column, Put Your Oxygen Mask on before Helping Others: The Importance of Wellness

The 2021 Opening Ceremony will unite leaders in the specialty, a groundbreaking keynote speaker, and enthusiastic attendees, setting the tone and pace for the Annual Meeting & OTO Experience. Don't miss this special event at 8:00 am (PT) on Sunday, October 3.

In addition to Dr. Sangwan's keynote address, you will also hear from Academy leaders during the Opening Ceremony. **Carol R. Bradford, MD, MS**, AAO-HNS/F President, and **James C. Denny III, MD**, AAO-HNS/F Executive Vice President and CEO, will discuss the specialty and provide the latest Academy updates. You won't want to miss the debut of special video presentations that highlight our unique specialty's history and future.



AAO-HNSF 2021 ANNUAL MEETING & OTO EXPERIENCE

AAO-HNSF 2021 Annual Meeting Guest Lecturers

Listed in order of appearance

Registration Opens June 21

Visit
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and updates to plan your
Annual Meeting experience!

JOHN CONLEY, MD
LECTURE ON MEDICAL ETHICS
Sunday, October 3, 2:00 – 3:00 pm (PT)

Health Equity as the Bullseye of the Quadruple Aim: A Social and Moral Imperative

J. Nwando (Onyejekwe) Olayiwola,
MD, MPH

J Nwando (Onyejekwe) Olayiwola, MD, is the chief health equity officer and senior vice president of Humana, Inc., and is an adjunct professor at The Ohio State University College of Medicine Department of Family and Community Medicine and The Ohio State University College of Public Health. She also serves as a family physician at the Heart of Ohio Community Health Center.



Throughout her career, Dr. Olayiwola has championed health equity. In her current role at Humana, she is responsible for setting a health equity agenda and strategy to promote health equity across the business. At Ohio State, she serves as a faculty advisor on anti-oppression, health disparities, and health equity research, programs, and policies. She is also the co-chair of the Ohio State Medical Center's Anti-Racism Action Plan Oversight Committee.

Dr. Olayiwola's expertise also encompasses COVID-19-related telehealth expansion, primary care operations, and improving the digital divide.

She received her bachelor's degree from Ohio State and her medical degree from Ohio State/Cleveland Clinic Foundation. She completed her residency in family medicine at Columbia University and New York Presbyterian Hospital. Dr. Olayiwola completed a Commonwealth Fund/Harvard University Fellowship in minority health policy at Harvard Medical School and received a master's degree in public health from the Harvard School of Public Health. ■

EUGENE N. MYERS, MD
**INTERNATIONAL LECTURE
ON HEAD AND NECK CANCER**
Monday, October 4, 8:45 – 9:45 am (PT)

The Clinical-Research Continuum: From Perineural Spread to Moving Surface Receptors in Improving Patient Outcomes

Ben Panizza, MBBS, FRACS, MBA

Ben Panizza, MBBS, is the director of otolaryngology-head and neck surgery at Princess Alexandra Hospital in Brisbane, Australia, and the chair of ENT Services for Metro South Health. He also is the director of the Queensland Head and Neck Cancer Centre, a research collaborative. As well, Dr. Panizza is a full professor of surgery in the Faculty of Medicine at the University of Queensland.



Dr. Panizza's research interests include head and neck cancers and skull base surgery. He is the lead investigator in a number of clinical trials, including a National Health and Medical Research Council grant-funded study on opportunities for treatment of incurable cancers. He has authored multiple research papers and textbook chapters, lectures internationally, and serves on the editorial boards of scientific journals.

Dr. Panizza established the Queensland Skull Base Unit at Princess Alexandra Hospital in 2006 and served as its co-director until 2017. He is the president of the Australian and New Zealand Skull Base Society.

Dr. Panizza graduated from the University of Queensland and completed his specialist qualifications in Queensland. He then completed a fellowship in head and neck/skull base surgery in London and another fellowship in otology/neurotology/skull base surgery in Italy. ■

H. BRYAN NEEL III, MD, PHD
DISTINGUISHED RESEARCH LECTURE
Monday, October 4, 2:30 – 3:30 pm (PT)
Idiopathic Subglottic Stenosis
Arises at the Interface
of Host and Pathogen
Alexander H. Gelbard, MD

Alexander H. Gelbard, MD, is an associate professor of Otolaryngology-Head and Neck Surgery at Vanderbilt University in Nashville, Tennessee, where he serves as the codirector of the Vanderbilt Center for Complex Airway Reconstruction. He is also the managing director of the North American Airway Collaborative, a multi-institution consortium with 40 participating centers in the United States and Europe that works to exchange information about the treatment of airway disease.

Dr. Gelbard's research focuses on laryngeal and tracheal disease. He is a National Institutes of Health principal investigator studying the immunologic mechanisms underlying benign laryngeal and tracheal disease. He is also the principal investigator on a prospective multi-institutional study of idiopathic subglottic stenosis. In addition, Dr. Gelbard has authored numerous peer-reviewed articles and book chapters and lectures internationally on adult airway disease.

He received his bachelor's degree from Stanford University and earned his medical degree from Tulane School of Medicine. Dr. Gelbard completed an internship and his residency at the Baylor College of Medicine. He then completed a postdoctoral research fellowship in immunology at the MD Anderson Cancer Center as well as a clinical fellowship in laryngeal surgery at Vanderbilt School of Medicine. ■



COTTON-FITTON
ENDOWED LECTURE
IN PEDIATRIC OTOLARYNGOLOGY
Tuesday, October 5, 8:45 – 9:45 am (PT)
What You See Depends on Where
You Stand
Ellen M. Friedman, MD

Ellen M. Friedman, MD, is the director for the Center for Professionalism in Medicine and a professor in the Bobby R. Alford Department of Otolaryngology at the Baylor College of Medicine in Houston, Texas.

Dr. Friedman's research interests include topics in pediatric otolaryngology as well as medical professionalism, education, and training. She has published more than 100 articles in peer-reviewed journals, is on the editorial boards of numerous journals, and produced a video on clinical medicine for *The New England Journal of Medicine*.

Prior to her current position, Dr. Friedman served as the chief of service at the Department of Pediatric Otolaryngology at Texas Children's Hospital, where she also served as president of the Medical Staff from 2011 to 2012. In addition, Dr. Friedman was the first woman to serve as the president of the American Society of Pediatric Otolaryngology and served as president for the American Broncho-Esophagological Association.

Dr. Friedman received her medical degree from the Albert Einstein College of Medicine and then completed an internship in surgery at Montefiore Medical Center. Thereafter, she completed an otolaryngology residency at Georgetown University School of Medicine and a pediatric otolaryngology fellowship at Boston Children's Hospital. ■



HOWARD P. HOUSE, MD
MEMORIAL LECTURE
FOR ADVANCES IN OTOTOLOGY
Tuesday, October 5, 2:30 – 3:30 pm (PT)
Transforming Health Through
the Convergence of Technology,
Information, and Life Sciences
Lloyd B. Minor, MD

Lloyd B. Minor, MD, is the Carl and Elizabeth Naumann Dean of Stanford University School of Medicine. He also serves as a professor of otolaryngology-head and neck surgery and, by courtesy, professor of Bioengineering and of Neurobiology at Stanford.

Dr. Minor's research interests focus on balance and inner ear disorders. His work has identified adaptive mechanisms responsible for compensation to vestibular injury in a model system for studies of motor learning (the vestibulo-ocular reflex). He and his colleagues discovered superior canal dehiscence syndrome. In 1998 they published a description of the clinical manifestations of the syndrome and related its cause to an opening in the bone covering the superior canal. He developed a surgical procedure that corrects the problem and alleviates symptoms.

Prior to joining Stanford, Dr. Minor became provost of Johns Hopkins University in 2009 where he also served as chair of the Department of otolaryngology-Head and Neck Surgery and otolaryngologist-in-chief at Johns Hopkins Hospital.

Dr. Minor received his bachelor's and medical degrees from Brown University. He completed a residency at Duke University Medical Center and a research fellowship at the University of Chicago. He then completed a clinical fellowship at The Otolaryngology Group and The EAR Foundation in Nashville, Tennessee. ■





AAO-HNSF 2021 ANNUAL MEETING & OTO EXPERIENCE

Schedule at a Glance

	October 2 SATURDAY	October 3 SUNDAY	October 4 MONDAY	October 5 TUESDAY	October 6 WEDNESDAY
6:00 am			OTOs on the Run 5K		
7:00 am		Sunrise Yoga	IAB General Assembly		Education Sessions
8:00 am		Opening Ceremony	Education Sessions	Education Sessions	
9:00 am			Myers Lecture	SRF General Assembly	Education Sessions
10:00 am		International Young Physicians Forum	Education Sessions	Great Debates	Education Sessions
11:00 am		Education Sessions	Education Sessions	Education Sessions	Education Sessions
12:00 pm		Great Debates	WIO General Assembly	Great Debates	Education Sessions
1:00 pm		Education Sessions	Great Debates	Education Sessions	
2:00 pm		Conley Lecture	YPS General Assembly	House Lecture	
3:00 pm		Education Sessions	Humanitarian Efforts Forum		
4:00 pm	BOG General Assembly		SIM Tank	Hall of Distinction Lecture	Education Sessions
5:00 pm	BOG Reception	Education Sessions		Reception	Education Sessions
6:00 pm			Simulation Showcase		
7:00 pm	Presidents' Reception			ENTrepreneur Faceoff	
8:00 pm					

Don't Miss Events Impacting Care of Patients, Practice, and Self

James C. Denny III, MD

AAO-HNS/F Executive Vice President and CEO

The last several years I have tried to preserve some time on the Annual Meeting & OTO Experience program to address topics and issues of concern to our members and specialty, which have tended to fall outside the normal education experience provided by our named lecturers and comprehensive scientific program developed by the Annual Meeting Program Committee (AMPC). Last year we included programming on the COVID-19 pandemic, focusing on testing, transmission, and immunity; wellbeing; a view from the lens of the AAO-HNS Future of Otolaryngology Task Force with a look at the future of otolaryngology practice; the future of telemedicine; and scientific breaking news that informed otolaryngology practice.

2021 EVP/CEO Spotlight Sessions

For this year's meeting in Los Angeles, California, the following features are in development:

- Exploration of the topic of wellness and resiliency as it relates to diversity and inclusion issues with a panel led by **Jo A. Schapiro, MD**, and **David J. Brown, MD**
- In-depth preview and discussion of the pros and cons of various types of physician employment models led by **Robert O. Brown III, MD**
- Analysis of the changes to day-to-day practice models resulting from the COVID-19 virus, including which of those practices will endure after the virus subsides with a session led by **Gavin Setzen, MD**, Past President and Chair of the AAO-HNS Future of Otolaryngology Task Force

“

We will also be introducing new initiatives and programs for patient-facing education, specialty promotion, Academy participation, and leadership in July and August. The ... additional programming will augment this year's innovative schedule of education opportunities provided by the AMPC. I encourage you all to take part in these supplemental activities ...

”

- Review of scientific and research updates on potentially game-changing, new, and innovative technologies in otolaryngology.

These topics, which are reflective of areas of focus by the Academy leadership historically but with greater emphasis this year, will continue into the future addressing the key areas of Wellness and Resiliency; Diversity, Equity, and Inclusion; and the Business of Medicine. The times and complete descriptions for these presentations will be forthcoming shortly.

Additionally, we will also be introducing new initiatives and programs for patient-facing education, specialty promotion, Academy participation, and leadership in July and August. They will also be featured at the upcoming meeting in Los Angeles.

The above-mentioned additional programming will augment this year's innovative schedule of education opportunities provided by the AMPC. I encourage you all to take part in these supplemental activities either live in Los Angeles or through our virtual platform at home. ■

Attend the General Assemblies

All locations are at the Los Angeles Convention Center unless otherwise noted, and all times are Pacific Time.

Board of Governors

Saturday, October 2, 4:00 – 5:00 pm
Held at Headquarter Hotel:
JW Marriott Los Angeles L.A. Live

International Advisory Board

Monday, October 4, 7:00 – 8:00 am

Women in Otolaryngology Section

Monday, October 4, 11:45 am – 12:45 pm

Young Physicians Section

Monday, October 4, 2:30 – 3:30 pm

Section for Residents and Fellows-in-Training

Tuesday, October 5, 8:45 – 9:45 am



AAO-HNSF 2021 ANNUAL MEETING & OTO EXPERIENCE

Registration Rates

REGISTRATION RATES	EARLY JUNE 21 - SEPTEMBER 7			REGULAR SEPTEMBER 8 - OCTOBER 17		
	FULL	DAILY	VIRTUAL ONLY	FULL	DAILY	VIRTUAL ONLY
MEMBER						
Domestic						
Resident/In-Training	\$335	\$155	\$158	\$510	\$195	\$158
Medical Students	\$150	\$90	\$158	\$185	\$105	\$158
Physician/Non-Physician	\$775	\$390	\$395	\$1,240	\$495	\$395
Advanced Practice Provider/Administrators	\$440	\$235	\$395	\$730	\$300	\$395
International						
Resident/In-Training	\$235	\$155	\$158	\$410	\$195	\$158
Medical Students	\$150	\$90	\$158	\$185	\$105	\$158
Physician/Non-Physician	\$675	\$290	\$320	\$1,140	\$395	\$320
Advanced Practice Provider/Administrators	\$440	\$135	\$320	\$730	\$200	\$320
International Lower Middle and Lower Income						
Resident/In-Training	\$176	\$116	\$158	\$308	\$146	\$158
Physician/Non-Physician	\$506	\$218	\$160	\$855	\$296	\$160
Advanced Practice Provider/Administrators	\$330	\$102	\$295	\$547	\$150	\$295
NONMEMBER						
Domestic						
Resident/In-Training/ Medical Student	\$555	\$270	\$357	\$875	\$345	\$357
Physician/Non-Physician	\$1,110	\$575	\$595	\$1,790	\$720	\$595
Advanced Practice Provider/Administrators	\$555	\$305	\$594	\$915	\$375	\$594
International						
Resident/In-Training/ Medical Student	\$430	\$145	\$175	\$735	\$205	\$195
Physician/Non-Physician	\$985	\$450	\$520	\$1,650	\$580	\$520
Advanced Practice Provider/Administrators	\$985	\$450	\$520	\$1,650	\$580	\$520
International Lower Middle and Lower Income						
Resident/In-Training/ Medical Student	\$323	\$109	\$145	\$551	\$154	\$175
Physician/Non-Physician	\$739	\$338	\$260	\$1,238	\$435	\$260
Advanced Practice Provider/Administrators	\$416	\$229	\$145	\$687	\$281	\$494

REGISTRATION RATES	EARLY JUNE 21 - SEPTEMBER 7		REGULAR SEPTEMBER 8 - OCTOBER 17	
	FULL	VIRTUAL ONLY	FULL	VIRTUAL ONLY
OTHER				
OTO Experience	\$100		\$150	N/A
OTO Experience Plus	\$225		\$285	N/A
Exhibitor Overallotment Fee	\$100		\$100	\$100
Exhibitor Full Access	\$865		\$1,530	N/A
Yoga			\$25	
OTOs on the Run 5K			\$75	
Presidents' Reception Additional Tickets				
Adult Guest			\$75	
Child (under 18 years of age)			\$25	
Additional Activities				
Exhibit Hall Lunch			\$50	
Spanish Webcast Only			\$75	
Shuttle Bus Pass			\$50	
125 Strong Donation	Can donate any amount			
Life Member Physician	\$675	\$304	\$1,140	\$513
Military Physician Member	\$775	\$349	\$775	\$349
Military Resident/ Student Member	\$335	\$153	\$335	\$153
Retired Physician	\$675	\$304	\$1,140	\$513

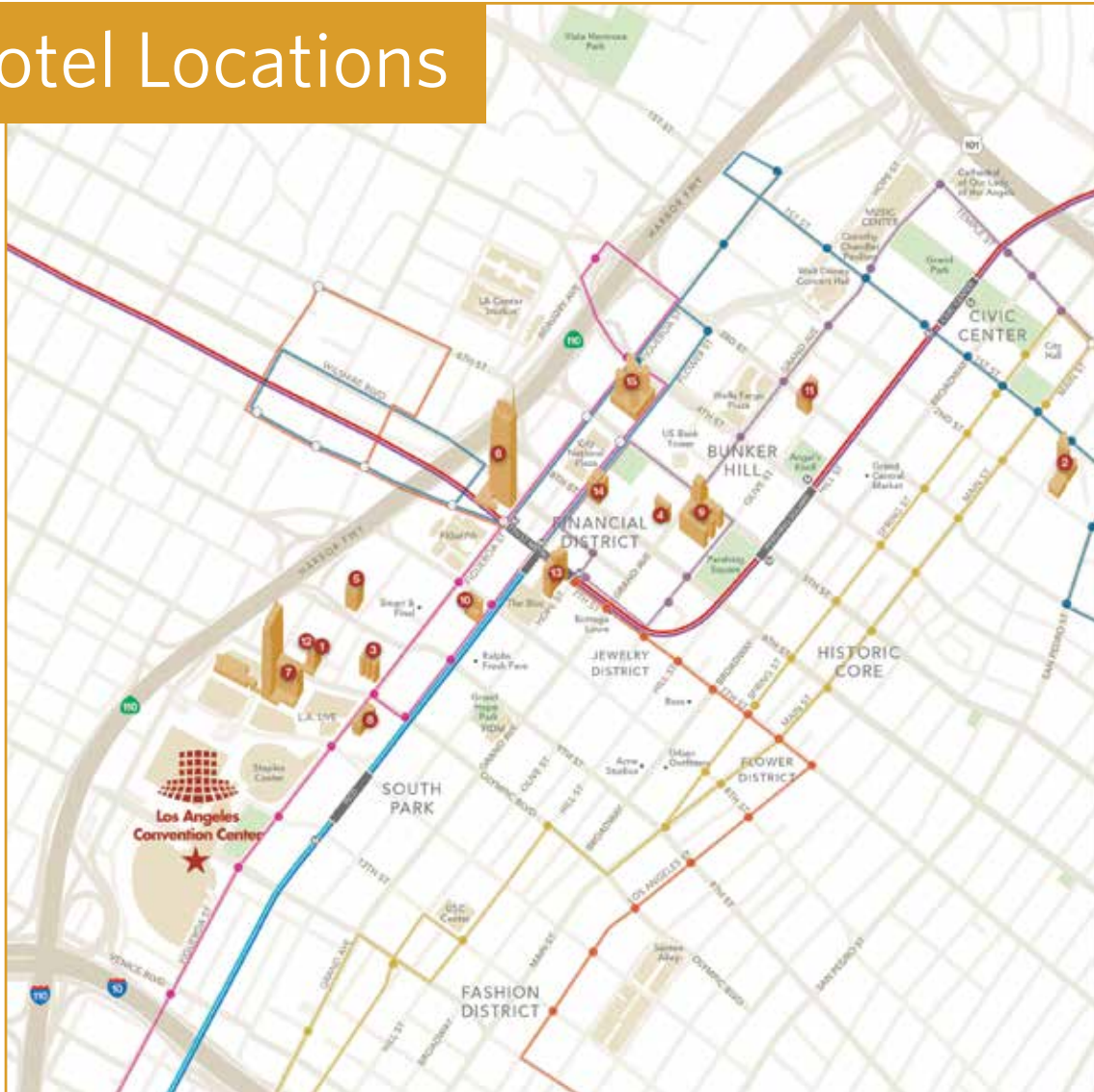
The Worst Case Scenarios: Managing OTO Emergencies in Practice Workshop Monday, October 4

EARLY JUNE 21 - SEPTEMBER 7	REGULAR SEPTEMBER 8 - OCTOBER 17
\$350	\$400

\$100 discount for International Guests of Honor for the AAO-HNSF 2021 Annual Meeting & OTO Experience are Australia, Brazil, Ghana, New Zealand, and Poland. Only one discount per attendee will be honored.



Hotel Locations



- ★ **Los Angeles Convention Center**
1201 S. Figueroa St.
- 1 **Courtyard by Marriott L.A. Live**
901 W. Olympic Blvd.
- 2 **DoubleTree by Hilton Hotel**
120 S. Los Angeles St.
- 3 **Hotel Figueroa**
939 S. Figueroa St.
- 4 **Hilton Checkers Los Angeles**
535 S. Grand Ave.
- 5 **Hotel Indigo LA Downtown**
899 Francisco St.
- 6 **InterContinental LA Downtown**
900 Wilshire Blvd.
- 7 **JW Marriott Los Angeles L.A. Live***
900 W. Olympic Blvd.
- 8 **E-Central Hotel**
1020 S. Figueroa St.
- 9 **Millennium Biltmore Hotel Los Angeles**
506 S. Grand Ave. A
- 10 **O HOTEL**
819 Flower St.
- 11 **Omni Los Angeles Hotel**
251 S. Olive St.
- 12 **Residence Inn Downtown L.A. Live**
901 W. Olympic Blvd.
- 13 **Sheraton Grand**
711 S. Hope St.
- 14 **The Standard Downtown L.A.**
550 Flower St.
- 15 **The Westin Bonaventure Hotel & Suites**
404 S. Figueroa St.

* HEADQUARTER HOTEL

Evaluation and Management of Eustachian Tube Dysfunction in the Geriatric Population

David J. Lafferty, DO, and Brian J. McKinnon, MD, MBA, MPH, members of the Geriatric Otolaryngology Committee

Introduction

Otologic and hearing complaints are the most common reasons that the elderly present to an otolaryngologist. While eustachian tube dysfunction (ETD) is a difficult disease to treat in the general population due to a lack of efficacious interventions available, it is even more difficult to treat in the geriatric population. This is because there is a gap in the literature regarding the evaluation and management of geriatric patients who present with ETD.

Evaluation

The initial evaluation should begin with a characterization of the patient's symptoms. Common symptoms of ETD include the sensation of aural fullness, popping, pain, pressure, clogging, and underwater sensation. There are three broad categories of ETD.

Acute dilatory ETD is usually brought on by an upper respiratory tract infection or an exacerbation of allergic rhinitis. It may be accompanied by a serous or acute otitis media. Chronic dilatory ETD presents with long-standing symptoms that are independent of any acute disease process. Baro-challenged-induced ETD is diagnosed in patients who are affected by changes in ambient pressure. This is common among flight attendants and scuba divers. Their physical exam is often normal upon presentation although if recently baro-challenged, they may have a serous effusion or hemotympanum.

Patulous ETD is unique from the others as the issue is a failure of the eustachian tube (ET) to close. This results in the presence of autophony—the defining characteristic that can be used to differentiate it from the other two types. Patients will report feeling as though they are talking into a wind tunnel and experience a loud echo or abnormally loud perception of their voice. This may be brought on spontaneously or by using decongestants, prolonged talking, and weight loss.

A recent publication by Fischer et al. showed that the prevalence of ETD among the elderly was 5.4%. This number was even higher in patients with a diagnosis of upper airway digestive tract cancer at 9.1%. They also noted that patients with a diagnosis of ETD were four to five times more likely to have a diagnosis of chronic rhinitis, chronic rhinosinusitis, and allergic sinusitis, and they were 2.4 times more likely to be diagnosed with reflux. These findings support the finding of ETD in a geriatric patient should prompt an evaluation for upper aerodigestive tract malignancy, sinonasal inflammatory disorders, and reflux.¹

Anatomic and Physiologic Differences in the Geriatric Population

Little is known regarding the underlying differences between ETD in the geriatric population versus the general population. Newman et al. noted that there are several anatomical changes of the middle ear and ET that occur during the aging process, including thinning and loss of efficient mobility of the tympanic membrane, stiffness of the ossicular

chain, and degeneration and atrophy of the intra-aural muscles and ligament fibers.²

Newman et al. determined that the ET in the geriatric population can be hypofunctional compared to the function of young adult ETs. Some degree of ETD was detected in 16.5% of an elderly sample in a nursing home. It is reasonable to assume that in addition to a generalized decrease in synergistic muscle activity and strength, the musculature of the ET would also be altered to some extent. Takasaki et al. verified this assumption in 1999 by comparing temporal bone specimens of individuals aged two days to 88 years. They determined that calcification of the ET cartilage and TVP muscle were closely associated with aging, likely predisposing elderly patients to ETD.³

Yamaguchi et al. determined that in patients over 60 years old, the duration of patency of the ET was shorter than that of patients younger than 60 years old.⁴ The ET is lined by pseudostratified columnar cells, but in adults over the age of 60 as well as children, increased numbers of non-functioning cells such as squamous and cuboidal cells have been appreciated when examined, leading to mucociliary dysfunction.⁵

Treatment

There is a paucity of literature guiding the treatment of ETD in the geriatric population. The usual treatment for ETD is aimed at addressing the underlying causes. The most common cause of dilatory ETD is mucosal inflammation within the cartilaginous ET, usually secondary to allergic rhinitis, chronic

rhinosinusitis, laryngopharyngeal reflux, and smoke exposure.⁶

Oral decongestants are known to affect comorbid conditions, such as high blood pressure, which are common in the elderly. First- and second-generation antihistamines have been associated with higher incidences of adverse effects. Intranasal corticosteroids have the most favorable safety and efficacy profiles in older adults with allergic rhinitis.⁷ A recent meta-analysis by Valenzuela et al. concluded that there is no evidence that intranasal corticosteroids are not associated with a significant risk of developing elevated intraocular pressure; however, the presence of glaucoma is a real clinical adverse event of concern. The decision to prescribe nasal steroids should be made to specifically treat an associated condition thought to be contributing to ETD, and not specifically to treat only ETD.

If medical and conservative therapy fails, surgical interventions may be considered. The gold standard for the treatment of ETD is the placement of short-term ventilating tubes. While effective, the tubes usually extrude within 6-12 months and patients are left wondering if there is a more permanent option available. Eustachian tube balloon dilation has been shown to be durable through 52 weeks in 57% of patients.⁸ It is important to note that the average age of patients in this study was 55.6 (Std 14.1), so it's unclear if these results can be extrapolated to the geriatric population. Regardless, we feel it is reasonable to present this option to the patient and a shared decision to proceed with balloon dilation may be made. ■

References

1. Fischer JL, Riley CA, Hsieh M-C, Marino MJ, Wu X-C, Mccoul ED. Prevalence of Eustachian Tube Dysfunction in the US Elderly Population. *Orig Res Otolaryngol Otolaryngol Neck Surg.* 2020;(6):1169-1177. doi:10.1177/0194599820932541
2. Newman CW, Spitzer JB. Eustachian Tube Efficiency of Geriatric Subjects. *Ear Hear.* 1981;2(3):103-107.
3. Takasaki K, Sando I, Balaban CD, Haginomori SI, Ishijima K, Kitagawa M. Histopathological changes of the eustachian tube cartilage and the tensor veli palatini muscle with aging. *Laryngoscope.* 1999;109(10):1679-1683. doi:10.1097/00005537-199910000-00024
4. Yamagushi T. Change with aging in eustachian tubal function--eustachian tubal function of normal ears. *Nihon Jibiinkoka Gakkai Kaiho.* 1994;87(4):668-673. doi:10.1017/CBO9781107415324.004
5. Tomoda K, Yamashita T, Kumazawa T. Scanning Electron Microscopic Study of Human Eustachian Tube Epithelium: Aging and Pathologic Changes. *Auris Nasus Larynx.* 1985;12:5169-5172. doi:10.1016/S0385-8146(85)80138-3
6. Adil E, Poe D. What is the full range of medical and surgical treatments available for patients with Eustachian tube dysfunction. *Curr Opin Otolaryngol Head Neck Surg.* 2014;22(1):8-15. doi:10.1097/MOO.0000000000000020
7. Slavin RG. Special considerations in treatment of allergic rhinitis in the elderly: Role of intranasal corticosteroids. *Allergy Asthma Proc.* 2010;31(3):179-184. doi:10.2500/aap.2010.31.3342
8. Anand V, Poe D, Dean M, et al. Balloon Dilation of the Eustachian Tube: 12-Month Follow-up of the Randomized Controlled Trial Treatment Group. *Otolaryngol - Head Neck Surg (United States).* 2019;160(4):687-694. doi:10.1177/0194599818821938



Considerations and Accommodations for the Geriatric Patient in Otolaryngologic Clinic

Ran Annie Wang, MD, and Brian J. McKinnon, MD, MBA, MPH, members of the Geriatric Otolaryngology Committee

Introduction

As of 2020, one in six people in the United States are over age 65; by 2030, it will be one in five. Geriatric care comprises 35% of hospitalizations and 27% of outpatient visits, with complexity of care increasing. Considering this, it is important for all physicians to evaluate, treat, and manage geriatric concerns. This review article presents observations and recommendations for the geriatric/disabled otolaryngology patient. This is not a comprehensive review but rather a starting point to discuss accommodations and effective communication for this growing population.

Sleep Medicine

Sleep concerns affect up to 70% of elders, and all elderly should be screened for sleep-disordered breathing. Comorbid conditions, such as reflux, can exacerbate sleep symptoms, and conservative treatment can improve subjective sleep quality and daytime function. Workup for geriatric sleep concerns should include a medication review with the Beers criteria in mind: Sleep-altering medications include tricyclic antidepressants, dopamine antagonists, diuretics, beta blockers, bronchodilators, and sympathomimetics. There is a growing role in otolaryngologic sleep procedures with drug-induced sleep endoscopy (DISE) and hypoglossal nerve stimulator implantation. As these procedures become more widely used, studies specific to elderly patients can be conducted.

Dizziness

Incidence of dizziness increases with age and is often multifactorial. Vestibular dizziness accounts for up to 14% of all cases. With vestibular testing, oVEMP and cVEMP tuning shifts to higher frequencies with older age, and cVEMP response decreases. Bilateral absent VEMPs become increasingly common with age (50% of patients over 40 do not generate oVEMP), which may lead to dizziness complaints. Benign paroxysmal positional vertigo (BPPV) incidence is twice as high in osteoporotic patients than in non-osteoporotic matched patients. Cervical spondylosis can increase risk of vertigo in patients aged 40-64, but not those 65 and above.

Anosmia

Anosmia/hyposmia affects 14%-22% of patients over 60 and significantly impacts safety and well-being. Sudden or distinct anosmia may be an early sign of neurodegenerative disease and warrants neurological workup. “Fluctuating” anosmia can be a sign of sinonasal disease. Treatments have continued to develop, with increased interest from COVID-19. Post-infectious anosmia shows spontaneous recovery in two-thirds of patients by three years. Post-traumatic anosmia shows limited recovery. Smell retraining therapy has consistently shown good results. Medications to consider include topical theophylline, steroids, sodium citrate, vitamin A, oral steroids, pentoxifylline, caroverine, and ginkgo biloba. For neurodegenerative anosmia, in vivo murine studies with topical fibroblast growth factor improved neural regeneration and smell restoration, but there have been no human trials.

Telemedicine

Telemedicine is a convenient and efficient means to address geriatric patient needs and decrease stress of scheduling and transportation. In assisted living facilities, 40% of complaints and 27% of emergency department visits could be appropriately assessed via telemedicine. Telemedicine has been pioneered for voice therapy and shows similar efficacy to in-person sessions. However, one problem for geriatric patients is difficulty with videoconferencing technology: 38% of elderly struggled with telemedicine or telephone calls, and 20% could not complete the telemedicine visit due to difficulty with hearing, seeing, mentation, or communicating. This is alleviated by a companion who is comfortable with the technology being present for the appointment. For those without companions, we can copy the popularized school nurse model of telemedicine—a trained healthcare professional familiar with current technology can perform basic history, a physical, and troubleshoot as needed. An on-site nurse or medical assistant can perform the same roles from a community center room or mobile clinic. For patients needing face-to-face assessment, the National Aging and Disability Transportation Center has resources for patients to arrange transportation if they cannot drive themselves.

Lessons from the Mask Mandate

Hearing loss affects 14%-15% of Americans, and COVID-19 mask mandates made clinic visits more difficult for many of our patients. For clinicians, a portable FM system amplifier set can help greatly. Patients with hearing aids can look into telecoils or other neck-loops and Bluetooth-enabled hearing



aid amplification. For cochlear implant patients, ClearVoice sound processors can be programmed to filter out background noise. Patients with dysphonia or progressive voice fatigue can be counseled on using portable amplifiers or tablets with text-to-speech function or writing capabilities.

Examination Room Layout

The clinic room layout has significant importance for people who use mobility assistance devices. As recently as 2016, up to 20% of wheelchair users reported difficulty with non-accessible barriers in clinic. The American Disability Act of 1990 outlines the following requirements for a clinical exam room to maximize accessibility:

- The entry door must be at least 32 inches wide and open at least 90 degrees.
- There must be 36 inches of space between the examination table, chair, and adjacent furniture.
- There must be open floor space of at least 30 inches by 48 inches inside the room.
- There must be enough clear floor space to allow a wheelchair user to make a 180 degree turn within the room.
- The room needs an examination table or chair that lowers to 17-19 inches above the ground.

Provider Positioning

Studies on communication with deaf patients recommend the following to maximize understanding:

- If an interpreter is present, they should be next to or slightly behind the provider.
- Do not stand between the patient and a bright light or window.
- Confirm with the patient their preferred method of communication first (verbal, writing, lip reading, etc.).
- Speak in simple, short phrases.

If a computer is in the clinic room, it should be placed so that the clinician can face the patient and type, but the computer (or laptop) is not between them. Another possibility is installing a floating desk on a wall that repositions as needed.

Written Information

For those using typed instructions, multiple typography studies show font choice can influence legibility and ease of reading. Serif fonts increase legibility for low-vision patients, but sans-serif fonts read faster. Verdana is the most easily readable font for adults. Fonts should be at least 10 points in size. Avoid excessive bold and highlighting as it decreases legibility. There are unique fonts being developed for adults with eye diseases, and typed electronic documents may be easily converted for these patients.

Elder Abuse:

Nuances in Otolaryngology

Elder abuse affects at least 10% of adults over 65, and all practitioners should be vigilant in screening. In otolaryngologic

clinics, suspicious behavior may be harder to distinguish. Caregivers of hard of hearing/deaf/dysphonic patients may speak over the patient automatically or express frustration frequently due to their familiarity with the patient. Some elderly may also be suffering from delusions of persecution, which complicates screening. Abusers are more often “friends” of the patient, have issues with alcoholism and/or psychiatric illness, have financial/social difficulty, and steadfastly refuse outside help. Risk factors for abuse include recent female widowhood, functional dependence, and history of urinary incontinence. The abused may seem unduly agitated or appear disheveled in clinic. While engaging in small talk, the elder or caretaker may disclose that the elder is suddenly deciding to change their will or sell their home.

When elder abuse is suspected, keep in mind the Pillemer and Modified Conflict Tactics scale for proposed criteria for elder abuse. Clinical questionnaires for documenting elder abuse include Indicators of Abuse, Elder Abuse and Neglect Assessment, and Elder Abuse Screening Test. Cases should be reported to Adult Protective Services or its equivalent. In the U.S., the National Center on Elder Abuse has listings for reporting elder abuse. The Eldercare Locator through the Department of Health and Human Services can also assist in finding appropriate resources. ■

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



OUT OF COMMITTEE: GERIATRIC OTOLARYNGOLOGY

COVID-19 Pandemic and the Elderly

Ozlem E. Tulunay-Ugur, MD, member of the Geriatric Otolaryngology Committee

The past year and a half have been an unprecedented time due to the COVID-19 pandemic with stories of desolation, agony, and loss, but also of heroism, resilience, and hope. No doubt the most affected population has been the elderly. The elderly, representing a specific cluster of high-risk patients for developing COVID-19 with rapidly progressive clinical deterioration, suffered the highest numbers of mortality.

Advanced age has been shown to be the most important predictor of fatal outcome due to COVID-19.¹ The Centers for Disease Control and Prevention (CDC) reports eight out of 10 COVID-19 deaths have been in adults older than 65 years of age.²

Immunosenescence is thought to be one of the major factors leading to poor response to the virus by the elderly, as well as physiological factors seen more commonly in the elderly, such as decline in the clearance of inhaled particles from the airway and greater airway collapsibility.^{1,3-5} Likewise, progressive and relatively linear increase

in nasal cavity volume with increasing age as well as age-dependent decrease of nasal resistance have been proposed as determinants for a higher prevalence of COVID-19 in the elderly population.¹

Until recently, the primary goal throughout the pandemic response has been to prevent the elderly from getting sick. This has mostly been through social distancing. We all stopped visiting our parents and grandparents fearing we would be the ones infecting them, nursing homes and care facilities went into lockdown, and multi-generational households struggled with

how to isolate in close quarters. “Cuddle curtains” made their way into our lives so the elderly can experience the much-needed human touch. Despite all efforts, many patients died alone, with families unable to comfort them during their last moments. Alzheimer’s patients have been affected even more so. Not being able to follow mask and sanitation recommendations, they have mostly been isolated to their own rooms, with complete upending of familiar routines, facies, and stimulation.

Older adults suddenly lost their support systems. A World Health Organization report in March 2020 stated “taking care of the older adults during the COVID-19 pandemic is everyone’s business.” Additionally they noted that governments should support those requiring help with access to nutritious food, basic supplies, healthcare, and money, and that the elderly should be treated with dignity.⁶ Unfortunately this was not the case for most and, in many instances, the elderly were blamed for causing the economy to collapse and have been chastised for being out of their homes; ageism has been widespread.⁷

Nevertheless, healthcare systems responded to the pandemic robustly and telemedicine increased exponentially, becoming an important part of all our daily practices. Unfortunately, the elderly were left disadvantaged. Fischer et al. reports the main factors that influence access to telemedicine are age, race, and education level. Respondents older than 65 years old reported significantly less willingness to participate in e-visits.⁸ Another important factor limiting the access to healthcare for the elderly was the fear of contracting COVID-19.

The mental health effects of the pandemic continue to be studied. Initial studies looking at the effects of social isolation on mental health revealed older adults did relatively better and showed fewer percentage of depression, anxiety, and trauma-related stress disorder compared to young adults.⁹ Similar results have been reported from other high-income countries, such as Spain and Canada.¹⁰ Van Tilburg et al., in a longitudinal study involving 1,679 community-dwelling

older adults (65-102 years) in the Netherlands, stated that although loneliness increased after the pandemic, mental health levels remained unchanged.¹¹ With the pandemic now going on for more than a year, further studies are needed to assess the long-term effects.

Once the initial response was implemented, it became obvious that we as physicians had to now learn how to manage the long-term consequences of the disease. The CDC reports that 9% of patients hospitalized for treatment required readmission to the same hospital within two months. The patients who were readmitted were more likely to be 65 years old or older, have chronic medical conditions, be hospitalized within three months prior to being diagnosed with COVID-19, and to have been discharged with home healthcare or to a short-term care facility.¹²

In the current phase of the pandemic with more older adults vaccinated, it is time to focus our efforts on the rehabilitation of the persistent otolaryngic effects of COVID-19. While further studies are needed to understand the extend of post-acute symptoms and persistent disability following COVID-19, some conditions have already been well documented, such as physical and mental disability; fatigue; respiratory, cardiac and renal impairments; speech and swallowing disorders; and nutritional deficits that persist for at least six months.¹³ The CDC also reports persistent symptoms, such as extended loss of taste and smell, cough, dyspnea, and dizziness, which will certainly lead to increased need for our specialty. Likewise, due to prolonged intubation and hospitalization of large numbers of elderly patients, we will see an increase in patients with subglottic and tracheal stenosis.

Our Academy and subspecialty societies have responded with an immense sense of duty. This vast amount of work was on display at a multispecialty panel during the recent Triological Society Meeting. The American Society of Geriatric Otolaryngology (ASGO) has been working diligently on various research projects as well as putting together a conference series

on geriatric care. The next meeting, a joint ASGO–Duke University symposium, will focus on perioperative care in the elderly. This will be followed by a presentation on Healthcare Inequities in Geriatric Otolaryngology in September. The series will end with a focus on taste and smell dysfunction in the aging. For more information, visit the ASGO website at <https://www.amsocgeriatricotolaryngology.org/meetings>.

The discussion of these issues could not be timelier. The pandemic has laid bare the inequities in being able to access healthcare, technology, nutrition, and basic necessities. Older people have been significantly affected with increased isolation, ageism, and even abuse. It is imperative to assess patients for signs of neglect and work on improving access to healthcare for older patients, all while focusing on rehabilitation of pandemic-related disorders. ■

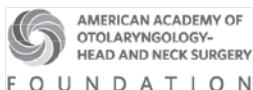
References

1. Perrotta F, Corbi G, Mazzeo G, et al. COVID-19 and the elderly: insights into pathogenesis and clinical decision-making. *Aging Clin Exp Res*. 2020;32:1599-1608.
2. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>
3. Svartengren M, Falk R, Philipson K. Long-term clearance from small airways decreases with age. *Eur Respir J*. 2005;26:609-615.
4. Levitzky MG. Effects of aging on the respiratory system. *Physiol*. 1984 Apr;27(2):102-107.
5. Martin SE, Mathur R, Marshall I. The effect of age, sex, obesity and posture on upper airway size. *Eur Respir J*. 1997;10:2087-2090.
6. <https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/4/supporting-older-people-during-the-covid-19-pandemic-is-everyones-business>
7. Skoog I. COVID-19 and mental health among older people in Sweden. *Int Psychogeriatr*. 2020;32:1173-1175.
8. Fischer SH, Ray KN, Mehrotra A, et al. Prevalence and characteristics of telehealth utilization in the United States. *JAMA Netw Open*. 2020;3:e2022302.
9. Vahia IV, Jeste DV, Reynolds CF. Older adults and the mental health effects of COVID-19. *JAMA*. 2020;324:2253-2254.
10. González-Sanguino C, Ausín B, Castellanos MA, et al. Mental health consequences during the initial stage of the 2020 coronavirus pandemic (COVID-19) in Spain. *Brain Behav Immun*. 2020;87:172-176.
11. Van Tilburg TG, Steinmetz S, Stolte E, et al. Loneliness and mental health during the COVID-19 pandemic. *J Gerontol B Psychol Sci Soc Sci*. 2020. <https://doi.org/10.1093/geronb/gbaa111>
12. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6945e2.htm>
13. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-conditions.html>



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