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President
Ken Yanagisawa, MD
Executive Vice President, CEO, and Editor of the Bulletin
James C. Denneny III, MD
Managing Editor
Tina Maggio
bulletin@entnet.org

INQUIRIES AND SUBMISSIONS
bulletin@entnet.org

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Ascend Media, LLC
Suzee Dittberner
Phone: 1-913-344-1420
Fax: 1-913-344-1492
sdittberner@ascendmedia.com

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Correction: In the print version of the December 2021/January 2022 issue (Volume 40, No. 11), there was an inaccurate description of the submission process on page 16. Please refer to the online version of this article for the most accurate information at **https://bulletin.entnet.org/home/article/21915992/annual-meeting-call-for-science-reflections-inspiration-at-otomtg21-lays-groundwork-for-otomtg22-call-for-science**.

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Mentorship

"We make a living by what we get, but we make a life by what we give." - Winston Churchill

In our personal and particularly our professional lives, we all seek a champion to help us discover, germinate, and grow our seeds of potential. We are fortunate in otolaryngology to be blessed with so many amazing mentors to teach and guide us to realize our hopes and ambitions.

Mentorship comes in many flavors. Some guide by example. Others are more vocal, articulating and delineating steps in the pathways to discovery. The art of mentorship is to motivate and challenge individuals to reach beyond their comfort zone and to achieve levels that were not previously recognized. As Steven Spielberg noted, *"The delicate balance of mentoring someone is not creating them in your own image, but giving them the opportunity to create themselves."*

As a mentor, complete dedication and prioritization of this role is critical. It takes time and energy, precious commodities in our current world. Showing our humanistic side conveys trust and confidence and can bolster a mentor-mentee relationship.

As a mentee, schedule protected times to meet with your mentor and to work united as a team. Be punctual for appointments avoiding distractions. Actively listen, set common goals, boldly put into motion ideas or strategies, and grow together.

The two-way learning process of mentoring is priceless—just as mentors share wisdom with the mentee, mentors often learn much about themselves in the process.

The beneficial cycle of mentoring was reflected in a study that showed nearly 90% of individuals who are mentored will proceed to mentor others themselves. Incorporating new skillsets, participating in networking with other colleagues, and building confidence with successes and even daring to venture forward will often lead to a desire to give back and help the next round or generation of mentees.

My personal and professional mentor was my father, **Dr. Eiji Yanagisawa**, who taught me to always believe in myself, and to approach all projects with hard work, honesty, and respect. **Dr. Linda Bartoshuk**, a pioneer in taste research at Yale, instilled in me an appreciation of the beauties and perils of scientific research, and maintaining perseverance even when things looked grim— these extrapolated into valuable life lessons. Of course, natural mentors for most of us are our residency or program chairs and faculty, and there is increasing attention toward mentorship programs in training curriculums. My chair, the late **Dr. Clarence Sasaki**, mentored brilliantly by example and by expectation.

Our Academy's framework permits many opportunities for members to identify and discover mentors. To name a few:

- *AAO-HNS Mentorship Program* matches medical students with otolaryngologists to learn about the pathway to otolaryngology residency and life as an otolaryngologist.
- *Committees* are an excellent forum for new and young members to join and learn from experienced members.
- *Board of Governors* is our grassroots member network comprised of local, state, regional and national societies. This is a wonderful venue for members to join, learn, and be mentored in the vital areas of advocacy and socioeconomic affairs.
- *Sections of the AAO-HNS – Women In Otolaryngology, Young Physicians Section, Section for Residents and Fellows-in Training.* These sections (and the *Diversity and Inclusivity Committee*) are unique and wonderful "homes" for members and serve to bring vision, strategies, and understanding about success and advancement within our organization and provide valuable leadership tract offerings.
- *Private Practice Study Group* is an exciting group that is quickly gaining traction and strength in uniting private practitioners from around the country, including those who struggled to feel connected to our Academy. This venture will bring important mentorship and leadership opportunities, especially as it continues to grow into Section status.

As we hopefully return to more in-person events, take advantage of the many opportunities to connect with colleagues and trainees, share stories and experiences, seek advice, and solidify bonds and relationships. As we are all aware, many mentorships do come to an end, but it is particularly rewarding to rekindle previous mentor-mentee relationships on a periodic basis as we progress through our life adventures together.

If one ever questions his/her capabilities or options, seek a trusted mentor's advice and counsel, and, *"Dream until your dreams come true."–Aerosmith* ■

Ken Yanagisawa, MD
AAO-HNS/F President

> The art of mentorship is to motivate and challenge individuals to reach beyond their comfort zone and to achieve levels that were not previously recognized.

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William Prentice, CEO, Ambulatory Surgical Centers Association
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Please Note: The program is subject to change. A final detailed program will be emailed to all registrants and additional information can be viewed online.

Volunteerism Is a Currency that Always Appreciates

So many members have given so much to the Academy over the last several years despite very trying times. They have volunteered their time, energy, and resources to advance the mission of the Academy and otolaryngology and ultimately patient care even though they themselves have experienced personal and professional hardships and increasing personal risk in addition to the everchanging working conditions they face daily. I would like to recognize, thank, and salute the hundreds of our domestic and international members and our staff who have fueled our organization and allowed it to flourish through their generous contributions during the toughest of times.

Elizabeth Andrew's statement, "Volunteers do not necessarily have the time; they have the HEART!" certainly is reflective of the situation facing the majority of our members regardless of whether they practice academic medicine, are employed, have their own private practice, are in an urban or rural setting, are a comprehensive practitioner or specialist, or are a student, resident, or fellow, or a 40-year veteran. The culture of volunteerism isn't developed, driven, or maintained by a desire for financial gain, public recognition, or advancement, but rather a profound commitment to a cause and mission they believe in. Physicians and others in the medical field also are inherently driven to serve others as a core aspect of the professionalism ingrained in them. Additionally, volunteers must believe that the time, energy, resources, or money that they donate is consistent with the mission they are supporting, as well as advances the cause they are working on and makes a difference to their target beneficiaries.

The Academy and Foundation could not financially afford to design and produce any of our education products, such as FLEX, podcasts, webinars, videos, or Annual Meeting programming, without the thousands of volunteer hours donated on our behalf to benefit patient care. Sherry Anderson observed, "Volunteers don't get paid, not because they're worthless, but because they're priceless." That is certainly the case with all our members who make the broad portfolio of our programs possible. Our quality programs continue to produce critical Clinical Practice Guidelines, Expert Consensus Statements, and Performance Measures that have led to critical patient care improvements over many years. Our clinical data registry, Reg-ent[SM], would never have gotten off the ground without the governing Executive Committee and the Clinical Advisory Committees and especially the members who chose to volunteer to participate in this critical quality program from the beginning. There are roughly 80 committees or task forces that all make meaningful contributions to our efforts, most of which I have not listed due to space constraints, but you can access the list on our website at **https://www.entnet.org/committees/**.

Finally, I would like to pay special tribute to those who make themselves available to be elected leaders of the organization as an Officer or member of the Board of Directors, Board of Governors, or Governing Councils of our Sections. I would also like to give special recognition to the leaders of the 125 Strong Campaign and the Annual Meeting Program Committee, as well as members of the Combined Otolaryngology Research Efforts Committee, the Awards Committee, 3P Workgroup, and the Finance and Investment Subcommittee for all their efforts on our behalf.

I am honored to be a part of the staff who works for an organization with such a rich heritage of volunteerism over our 125-year history that includes our leaders, committee and task force members, speakers, authors, donors, advocates, participants in Academy/Foundation programs, and the host of other members who volunteer when needed for their personal contributions that produce the fantastic opportunities we wouldn't have without you. I pledge to you that we will do the absolute best we can to maximize all that you do for the organization and specialty and fulfill our mission. ■

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

> "I would like to recognize, thank, and salute the hundreds of our domestic and international members and our staff who have fueled our organization and allowed it to flourish through their generous contributions during the toughest of times."

2022 Call for AAO-HNS/F Awards Nominees

AAO-HNS/F HONORARY AWARDS

Online applications are being accepted for the Academy's various recognitions of outstanding physicians, committees, and societies that have gone above and beyond this past year. Visit **www.entnet.org/awards** for additional information on each award, including past recipients and submission criteria and to nominate a deserving physician, committee, or society. The application deadline for all awards is March 15, 2022. The Academy has one application for all award submissions to make it easier to make your nominations.

Nikhil J. Bhatt, MD International Humanitarian Award
The Nikhil J. Bhatt, MD International Humanitarian Award honors a non-U.S. otolaryngologist-head and neck surgeon who has selflessly treated people for whom access to care would have been financially or physically prohibitive. The award is in fulfillment of the AAO-HNSF's aim to foster a global otolaryngology community and made possible through the generosity of Nikhil J. Bhatt, MD, a longtime advocate of AAO-HNSF international affairs. (Awardee decision made by the Awards Committee)

Nikhil J. Bhatt, MD International Public Service Award
The Nikhil J. Bhatt, MD International Public Service Award honors a non-U.S. otolaryngologist-head and neck surgeons whose achievements have advanced the specialty. The Award is in fulfillment of the AAO-HNSF's aim to foster a global otolaryngology community. (Awardee decision made by the Awards Committee)

BOG Model Society Award
The Board of Governors (BOG) Model Society Award recognizes outstanding local/state/regional societies that exhibit effective leadership, institute Academy and Foundation programs, and further Academy goals through active participation in the BOG. (Awardee decision made by the BOG)

BOG Practitioner Excellence Award
The Board of Governors Practitioner Excellence Award recognizes the prototypical clinical otolaryngologist one wishes to emulate. Board of Governors Representatives will nominate individuals who, within the past 10 years, have practiced medicine in an exemplary manner and are sought out by other physicians because of their personal and effective care. (Awardee decision made by the BOG)

AAO-HNS/F Committee Excellence Award
The Committee Excellence Award recognizes committees that contribute in ways that lead to the overall success of the AAO-HNS/F vision as the global leader in optimizing quality ear, nose, and throat care. These committees have a passion for the AAO-HNS/F's vision and for accomplishing the activities outlined in the AAO-HNS/F Strategic Plan. (Awardee decision made by the Awards Committee)

Distinguished Award for Humanitarian Service
The Distinguished Award for Humanitarian Service recognizes an Academy member who is widely known for a consistent, stable character distinguished by honesty, zeal for truth, integrity, love for and devotion to humanity, and a self-giving spirit. The awardee is an outstanding example and model to emulate for a life dedicated to a nobler, more righteous, and more productive way for the human to live as an individual on this earth. The awardee is well known for professional excellence and has demonstrated professional dedication by the giving of professional skills freely, and without desire for personal gain or aggrandizement, to those in this world who cannot otherwise, physically and financially, receive them.

Hall of Distinction Awards
The first Hall of Distinction inductees were awarded at the AAO-HNSF 2021 Annual Meeting & OTO Experience in Los Angeles, California, on Tuesday, October 5. The Awards Task Force selected a total of 12 inductees—six physician pioneers, providing posthumous recognition of giants in the field, and six modern day trailblazers, who continue to be active members of the global otolaryngology community. (Awardee decision made by the Awards Committee)

The Holt Leadership Award for Residents and Fellows-in-Training
The Holt Leadership Award is awarded annually to the Resident or Fellow-in-Training who best exemplifies the attributes of a young leader: honesty, integrity, fairness, advocacy, and enthusiasm. The award recognizes exemplary efforts on behalf of the Section for Residents and Fellows-in-Training of the AAO-HNS/F for the promotion of the missions and goals of the association. (Awardee decision made by the Awards Committee)

Jerome C. Goldstein, MD Public Service Award
This award recognizes Academy members for commitment and achievement in service, either to the public or to other organizations within the United States, when such service promises to improve patient welfare. Funded anonymously by an Academy member, any member of the Academy is eligible to receive and nominate other members for this award. The awardee is honored during the Annual Meeting & OTO Experience with a commemorative certificate and $1,000 honorarium. (Awardee decision made by the Awards Committee)

WIO Exemplary Senior Trainee Award
This award recognizes an outstanding female senior resident or fellow in an otolaryngology-head and neck surgery training program who demonstrates excellence in leadership, research, education, and mentoring. (Awardee decision made by the WIO)

WIO Helen F. Krause, MD Trailblazer Award
This award recognizes an individual who has furthered the interests of women in the field of otolaryngology. (Awardee decision made by the WIO)

WIO He for She Award
This award recognizes a male otolaryngologist who serves as a strong mentor, collaborator, and sponsor of women in otolaryngology. (Awardee decision made by the WIO)

YPS Model Mentor Award
Having a good mentor is important to every phase of a physician's career but perhaps never more critical than in the earliest years out of training. Recognizing the key role that expert mentorship plays in a young physician's success, the YPS has created the Model Mentor Award. (Awardee decision made by the YPS)

YPS IMPACT Award
Young physicians are often overlooked or not qualified enough for many of the awards available in our specialty, yet many young physicians are quite remarkable with regard to the impact they have on education, service to their community, service to their profession, and humanitarian work. The YPS would like to recognize these individuals not only for the work they achieve but also for the inspiration they provide to others. (Awardee decision made by the YPS) ■

Questions about the awards program? Email **awards@entnet.org**.

Top 100 CPT Codes

The American Academy of Otolaryngology–Head and Neck Surgery has prepared new resources for members outlining the Top 100 Current Procedural Terminology (CPT) codes reported by providers with the subspecialty designation of "4-Otolaryngology" within the Medicare enrollment database. Two charts are now available:

2022 Top 100 ENT Codes Billed in a Physician Office:
The 100 most commonly reported codes in the physician office site of service.

2022 Top 100 ENT Codes Billed in the Hospital Outpatient Department:
The 100 most commonly reported codes in the hospital outpatient site of service.

Volume for both charts is based on 2020 Medicare claims data, the most recent year for which data are available. Further information and the chart files can be accessed as part of the Academy's Coding Corner (**https://www.entnet.org/content/coding-corner**).

ENThealth
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World Hearing Day: To Hear for Life, Listen with Care!

The World Health Organization founded World Hearing Day to raise awareness on how to prevent deafness and hearing loss and promote ear and hearing care throughout the world. World Hearing Day is observed annually on March 3.

Looking for materials to share with your patients? **ENThealth.org** is a dynamic patient health website—a consumer-facing online resource for patient-centered otolaryngology-head and neck surgery information with extensive information on hearing-related conditions and treatments as well as wellness and prevention articles.

OTOSOURCE
COMPREHENSIVE OTOLARYNGOLOGY CURRICULUM

Education Opportunities in Pediatrics

Explore the OTO Source Pediatric Otolaryngology Unit and select from multiple modules and surgical videos covering topics from genetic testing through other conditions, such as adenotonsillar disease, pediatric rhinosinusitis, deep neck space infections, and more. All resources are free and available at **www.otosource.org.**

INTERNATIONAL ADVISORY BOARD

Call for IAB Chair-Elect Nominees

Are you interested in holding a global leadership position within the Academy, or can you recommend a colleague? The AAO-HNS is seeking nominees to serve as Chair-elect of the International Advisory Board (IAB) starting on October 1, 2022, through September 30, 2023, and as Chair in 2023-2024.

Candidates must be Academy members in good standing and practicing outside the United States and affiliated with an AAO-HNSF International Corresponding Society to qualify. The election will be held September 10-14 during the AAO-HNSF 2022 Annual Meeting & OTO Experience in Philadelphia, Pennsylvania. Deadline for submission is April 1, 2022.

WIO DAY IS MARCH 8

Women in Otolaryngology Day is celebrated yearly on March 8 to coincide with International Women's Day. Its purpose is to acknowledge the myriad accomplishments of women otolaryngologists and to inspire the next generation of women leaders in our field.

We encourage you to find creative and memorable ways to celebrate WIO Day 2022 with your colleagues and community!

Please share your photos and experiences on the WIO page on ENT Connect and through social media networks tagging the Academy at **@AAOHNS** and using the following hashtags: **#WIOday** | **#WIO** | **#otolaryngology**

WIO WOMEN IN OTOLARYNGOLOGY

WIO's Continued Focus on Wellness

Priya D. Krishna, MD
WIO Chair

WIO Day is right around the corner on March 8 and the ideal time to recognize our colleagues, not only for the amazing work they do but in how they help, advise, and mentor other women otolaryngologist-head and neck surgeons. The Women in Otolaryngology Section (WIO), working with the Academy staff, has come up with a fun way to celebrate WIO Day and recognize our outstanding women members.

On March 8, we'll share a link via the WIO ENT Connect community and other platforms that will include instructions and social media materials to commemorate WIO Day 2022. This information will detail how to submit a short testimonial recognizing one or more of your colleagues that will be published on the Academy's WIO page for all members to read and enjoy. It will also have downloadable social media graphics and materials that you can personalize and share on your own social media networks. This is just one way this year to take a bow and celebrate each other during this challenging environment.

Supporting each other and recognizing the mental and physical strain we each may be experiencing during these tumultuous times, it is now more important than ever to address burnout and focus on wellness. As we all know, wellness can refer to our emotional or physical well-being, or both. The WIO is focusing on promoting physical wellness through a series of programs over the next several months and at the AAO-HNSF 2022 Annual Meeting & OTO Experience this fall.

As an example, work-related musculoskeletal disorders (WMSDs) are extraordinarily prevalent in surgeons, and surgical ergonomics is an area that we are planning on addressing. A recent study cited an over 70% prevalence of back and neck pain in otolaryngologists at a single institution,[1-2] similar to what exists in other surgical specialties and thus indicating a pervasive problem. WMSDs impact productivity and, in surgery, that may translate to poorer patient outcomes. Risks factors for WMSDs include younger age, shorter surgeon stature, female gender, and smaller glove size. Therefore, the impact of WMSDs may only deepen as more women enter our field, making it imperative that we discuss and educate ourselves on this issue comprehensively. ■

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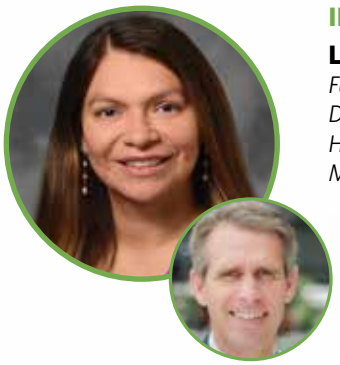


INTERVIEWEE

Laura R. Garcia-Rodriguez, MD
Facial Plastic and Reconstructive Surgery
Department of Otolaryngology-Head and Neck Surgery
Henry Ford Health System
Member of the Facial Plastic and Reconstructive Surgery Education Committee

INTERVIEWER

Daniel Knott, MD
Professor, Department of Otolaryngology
University of California San Francisco
Chair, Facial Plastic and Reconstructive Surgery Education Committee

How does a practice evolve over time and through self-reflection?

The "time off" forced upon us during the initial phase of the pandemic provided an important pause in our lives permitting some self-reflection. As surgeons we continually strive to be the best for each surgery. Best outcomes are particularly imperative for a cash-based practice. Once completing a surgical case, we would like to think we have made all the right decisions. After all, we complete each case with the very best of our abilities. Having a couple of years under my belt, I realize that my skills continue to improve. As a facial plastic surgeon, the skills I employed for an aesthetic rhinoplasty several years ago are different than my current skills. Our photographs are our memories of the "what if" or "if I had" done a given surgery differently. The photographs are not just actual memories but factual representation of our work. Each case is different, and we take a different element away.

Why does our work always feel unfinished?

As an academician, my hands have had to learn to operate secondhand. Technology has made it much easier to teach difficult maneuvers and techniques, such as with endoscopic septoplasty. I can tell if a resident is forceful by their hand movements as well if we are operating without an endoscope. In the area of endoscopic surgery, even a before and after picture of an endoscopic septoplasty yields much attention. Furthermore, with each case I take an experiential "piece" home with me each day, hoping that it will help me eventually solve a much grander puzzle.

There is always a missing piece since there is so much left to learn. I'm always chasing a "better self/role model" since the puzzle never seems to be complete. Maybe in five years I'll ask myself the same thing. Am I the best I am? Yes, just for that moment, since the puzzle pieces keep adding. Then in 10 years I'll ask myself the same thing—am I the best?— well yes, just for that moment. Each day we earn a new piece for the never-ending puzzle called operative perfection. In a cash-paying practice this is inherently important because the expectation of perfection is there, but perfection is a moment in time. The perception of beautiful work in the present may be "okay" for our futures selves due to changing practices, beliefs, and improvement. ■

Spotlight: Humanitarian Efforts

H. Charlie Lin, MSN, APRN, NP-C, CNOR, CNAMB, RNFA, FCN

Nurse Practitioner, Division of Pediatric Otolaryngology, Lucile Packard Children's Hospital / Stanford Children's Health
Clinical Assistant Professor of Medicine, Master of Science in PA Studies Program, Stanford School of Medicine
Adjunct Faculty, Delaware County Community College - RN First Assistant Program
AHA BLS & ACLS Instructor

Tell us a little about yourself.

I am a family nurse practitioner working in pediatric otolaryngology at Stanford Children's Health in Palo Alto, California. My clinical interests include pediatric airway, microtia reconstruction, as well as chemosensory dysfunction. I received my bachelor's and master's degrees in nursing from West Texas A&M University in Canyon, Texas. Additionally, I completed my RN first assistant certificate at Delaware County Community College in Media, Pennsylvania.

I worked for years as a nurse in emergency departments and operating rooms (ORs) at several facilities in North Dallas, Texas, before completing my nurse practitioner program. It was in the OR that I discovered my passion for otolaryngology under the guidance of **Lav A. Kapadia, MD**, of Ear, Nose and Throat Associates of Texas. In search of a position within our wonderful specialty, I began my career in ENT after being trained by the excellent ENTs at UConn John Dempsey Hospital in Farmington, Connecticut. For many years now, I have had the privilege to serve as a OR nurse leader with LEAP Global Missions, a nonprofit organization based in Dallas, Texas.

Describe the humanitarian missions you are involved in.

I have been involved in humanitarian missions for 10 years, having gone on more than 25 trips to Central and South America, the Caribbean, and Asia. From craniofacial/plastics, general surgery, and ophthalmology to urology and ENT, I have had the privilege to serve as an OR nurse leader with LEAP Global Missions, a nonprofit organization based in Dallas, Texas, and in the roles of team or mission leader, circulator, surgical assist, and recovery nurse.

Our patients come from orphanages and families with insufficient financial resources or lack local access to operative procedures. Our trips range from four days to two weeks, depending on the country we travel to. We work with local contacts or agencies to spread the word of what services we offer and enjoy seeing the progress of our patients on subsequent trips. Many of our patients go on to tell their stories of how their procedures have impacted their lives and then share their families with us.

A few years ago, I was asked to help develop our newest mission to Zihuantanejo, Mexico, where we perform microtia reconstructions. This mission is especially meaningful as we get to see these patients at each stage of the procedure grow in personality and confidence. After the mission is complete, I stay behind to see these patients in my post-op clinic before returning to the States.

Additionally, I have served with MOVE Missions as an OR circulator and first assist performing total joint arthroplasty in the Dominican Republic. In this organization, we partner with a local church and fund many of the projects of a local school, taking time to engage with the students in learning and sports activities. This experience is not only meaningful because

we get to interact with students and watch them grow to become productive members of their communities, but we also get to help our surgical patients move with freedom again.

How can others get involved if they are interested?

First, talk to and engage with others who have participated in humanitarian missions and learn about their passions and experiences. Second, research organizations and determine if you can make the time commitment. If you feel that you are ready to experience a life-changing opportunity, fill out the application. You will never get involved if you don't fill out an application. Like LEAP Global Missions (**https://www.leapmissions.org/**), many mission agencies also have local partnership opportunities that may be more feasible for the busy clinician.

Provide some guidance for others interested in what you are doing.

I first got involved with LEAP Global Missions by word of mouth through a friend. After several surgeons and anesthesiologists heard of my mission adventures, they encouraged me to consider joining them on their trips with Faith in Practice and Mercy Ships. This is how I got involved with MOVE Missions. More healthcare personnel have participated in humanitarian surgical missions than we may realize, so be open to the opportunity for great conversations. Interested individuals could also consider joining International Disaster Surgical Relief teams.

How does the work you do impact you and the communities you serve?

Participating in these humanitarian efforts provides me with a different appreciation for the care that I provide to my patients in the United States. Our work abroad allows our patients to become more readily accepted as members of their communities, pursue their aspirations without fear of judgment, and be free of the financial strain associated with operative procedures.

We have the opportunity to build relationships with the locals and, in turn, partner with them to positively impact their community by providing things like a sound system for the local school or a basketball hoop in the community park. Seeing the excitement and joy in the eyes and smiles of each child or patient provides inspiration and reaffirmation for the work that we do and encourages me to continue participating in these endeavors.

In some countries, we have the distinct honor of partnering with the local college of nursing or medicine and providing student volunteers with educational opportunities that they are able to carry through their training.

Any final thoughts or areas that you would like to share?

If you have ever thought about serving someone overseas with your training and skills, now is the time to put that thought into action. The one life you change may change your own. ■

NOMINATE YOUR COLLEAGUES FOR AN AWARD

AAO-HNS/F 2022 Honorary Awards

The Academy is composed of extraordinary members who go above and beyond. Honor these individuals and their contributions to the specialty by nominating them for a prestigious award.

The streamlined nomination process makes submitting a nomination through one online application for all awards a quick and easy process. **Submit your nomination by March 15.**

Submit Your Nomination Today: **www.entnet.org/awards**

AAO-HNS/F 2022
LEADERSHIP FORUM & BOG SPRING MEETING
APRIL 9, 2022

Keeping You Connected

Troy D. Woodard, MD
Chair, Board of Governors

We will gather together virtually for a second year in a row on April 9 for the AAO-HNS/F 2022 Leadership Forum & BOG Spring Meeting. Whether you participate from your home or office, on your computer, phone, or tablet, in jeans, scrubs, or shorts, this meeting is an opportunity to connect to interesting sessions and dynamic speakers on a wide range of key topics for our specialty.

This year's meeting has something for everyone no matter your practice setting, level of experience, and specific interests. In developing the agenda, the planning committee's goal was to focus on sparking thought and discussion around some of the largest issues confronting our specialty—pay parity, advocacy, and diversity. We have many interesting and notable speakers tackling issues from healthcare disparities at the local level to integrating advanced practice providers, private equity firms, and audiology into your practice. In particular, I am excited to welcome Kate Stewart who will discuss the pay gap between male and female otolaryngologists, which is the highest in medicine* in her talk titled, "Raise Your Voice: Paving the Path for an Equitable Future." Read more about this presentation topic on pages 14-15.

Finally, we are bringing back a member favorite and will have presentations and Q&A with both candidates running for AAO-HNS/F President-elect.

Please plan to join your colleagues on April 9. Registration is now open, and participation is free for AAO-HNS members.

**Doximity 2021 Physician Compensation Report.* ■

REGISTER TODAY

Registration is free for all AAO-HNS Members
https://entnet-org.zoom.us/webinar/register/WN_w2vxxO4OROq0dr5RdrhOkw

A Sampling of the Don't Miss Programming for #BOGMTG22 Attendees:

The schedule is subject to change. Please visit **www.entnet.org/leadershipforum** for the most up-to-date programming.

Best Practices in Utilizing Advanced Practice Providers in Your Practice
Craig Kilgore
CEO, Charleston ENT and Allergy
Dianne Williams
CEO, ENT Associates of Alabama

Coding and Billing Update
R. Peter Manes, MD
Associate Professor, Yale School of Medicine
AAO-HNS Coordinator, Advocacy

Current State of Ambulatory Service Centers
William Prentice
CEO, Ambulatory Surgical Centers Association

Healthcare at the Grassroots Level
Joan F. Coker, MD
ENT & Allergy of Delaware

Keynote: Raise Your Voice: Paving the Path for an Equitable Future
Kate Stewart
Vice President and General Manager, ENT, Stryker

Legislative Update
U.S. Representative Greg Murphy (NC-03)

OTC Audiology: How to Prepare Your Practice
Brian Woodhead, MGA
Administrator, Otolaryngology-Head and Neck Surgery, Johns Hopkins University

Private Equity: What You Need to Know
Todd Blum, CEO
ENT and Allergy Associates of Florida

Social Determinants of Health and the Patient Experience
Michael G. Moore, MD
Arilla Spence DeVault Professor, Indiana University School of Medicine

AAO-HNS/F 2022
LEADERSHIP FORUM
& BOG SPRING MEETING
APRIL 9, 2022

#BOGMTG22 Features Keynote Presentation

Raise Your Voice: Paving the Path for

The AAO-HNS/F Leadership Forum & BOG Spring Meeting is featuring a keynote presentation by **Kate Stewart, Vice President and General Manager, ENT for Stryker**, on the topic of pay parity in healthcare. In an interview with the *Bulletin*, Ms. Stewart shares her insights on this topic and why this is a can't-miss event on April 9.

About Kate Stewart and Her Career's Journey

I am extremely passionate about what I do and very grateful to have had an extensive career in healthcare and the medical technology industry. I began my career as a physiotherapist in Sydney, Australia. I then joined Stryker, a global leader in medical technology, in 2006 for the Craniomaxillofacial division in Australia. Over the next 15 years, I held various commercial leadership positions across the globe with increasing scope and complexity, including in Asia Pacific, Europe, and North America, in our neurosurgery, craniomaxillofacial, and ENT businesses.

I have a very deep respect for the surgical community that we serve. I am also incredibly passionate about helping healthcare providers make a difference for their patients. That purpose comes from my personal experience. Seventeen years ago, I was 23 years old, working as a stroke rehabilitation physiotherapist and training as a triathlete. During a training session, I collapsed from dehydration. In the days following, I was admitted to the hospital with a venous sinus thrombosis. I don't remember much from that time, but what I do remember is that my neurosurgeon was incredibly caring and always made me feel like things were going to be OK.

I eventually recovered. However, when I was ready to go back to work, I didn't have the emotional strength to go back to the job I loved as a stroke therapist. Instead, I decided to embark on a career with a healthcare company like Stryker. I had only planned to stay for a year or two, after which I wanted to go back to being a stroke therapist. But after a year, I realized that I could still be as passionate about helping people working for Stryker as I could as a healthcare professional, and it has always just felt right.

REGISTER TODAY

Registration is free for all AAO-HNS Members
https://entnet-org.zoom.us/webinar/register/WN_w2vxxO4ORQq0dr5RdrhOkw

by Kate Stewart
an Equitable Future

What is pay parity, and how did you become involved in advocating to close the gender pay gap?

Pay parity means ensuring equal pay for equal work. Despite significant growth of women in the labor force and increasing education attainment, gender pay parity largely continues to be an issue across multiple industries.

There are several contributing factors that are referenced in a multitude of literature. Salary anchoring, preferential promotions, career breaks impacting years of experience, and selective opportunity targeting are the most commonly cited. Companies and leaders must work to address those issues.

I am a champion for diversity, equity, and inclusion and having mentored many women across different industries that face pay parity issues, I am passionate about advocating for equal pay for equal work. I am fortunate to work for a company that values diversity, equity, and inclusion and takes the issue of pay parity seriously.

What can individuals do to make a difference and effect change?

Certainly, we have work to do to achieve gender balance and equity opportunity across the MedTech and healthcare industry, but I am very inspired by the progress we are making and by the commitment that has been shown across our industry to make change. We should continue to address unconscious bias and barriers to opportunities while prioritizing the development of females as we advance our journey. The most powerful thing we can all do as individuals is use our voice to be an advocate for change.

What are some key points that you will be discussing during your presentation?

I will address how we can collectively raise our voices to influence change.

What efforts are underway at Stryker?

An essential part of our culture has always been the respect for each individual's strengths and values. To continue our journey, we have also formalized our company commitments for diversity, equity, and inclusion. We are committed to strengthening the diversity of our workforce; advancing a culture of inclusion, engagement, and belonging; and maximizing the power of inclusion to drive innovation and growth.

More than a decade ago, we founded Stryker's Women's Network (SWN). This employee resource group works to advocate for the advancement of women. Today we have over 7,600 members in over 35 countries and I am currently president of this global organization.

Our purpose at SWN is to improve Stryker's results by fostering an open and inclusive culture, with a focus on attracting, developing, and retaining talented women, and driving active engagement of our membership.

We accomplish this by advocating for representation of women on task forces, councils, and diverse interview slates; promoting a culture committed to seeing the authentic self in others; recognizing the value all individuals bring to work; engaging with others meaningfully to cultivate an inclusive culture; and empowering our members to be advocates for themselves and others to drive the advancement of women within Stryker.

Stryker recently hosted an event, "Nevertheless, She Persisted: Paving the Path for Future Generations of Medical Devices and Women in ENT," which addressed the journey toward equality for women, including the impact we have seen on that journey over the past two years.

The event was led by the head of ENT's Research & Development department, and we discussed the steps we are taking for inclusive design, which includes products that are designed for everyone. The stories shared by our surgeon panelists about their experiences were exceptionally powerful. This led to a unified commitment to raising our voices to change the future for the next generation of ENT women.

I have learned on our journey at Stryker that listening to those impacted is critical. In 2020 as a member of CEO Action, we launched "Days of Understanding," a global initiative designed to foster more in-depth conversations around the experiences and perspectives of our employees to understand the gaps and opportunities at Stryker. The results were aggregated and shared with leadership and functional teams who reviewed and committed to actions addressing what we heard.

We are also constantly working on job requirements, skill equivalencies, and how we evaluate experience by role, which has helped to ensure leadership stays focused to benefit and pay parity.

At Stryker, we have also been very intentional about investing in the development of our female talent to help them acquire new or advanced skills, knowledge, and viewpoints and offering avenues where they can apply new ideas.

If you have questions that you would like answered during the presentation, please email them to BOG@entnet.org. ■

FORWARD TOGETHER

AAO-HNSF 2022
ANNUAL MEETING & OTO EXPERIENCE
SEPTEMBER 10-14 PHILADELPHIA, PA

Call for Simulation Abstracts Coming Soon!

Do you have an innovative simulator model or simulation activity that you would like to share with the otolaryngology community? The Academy is now accepting proposals to be considered for presentation at the Simulation Reception & Showcase held during the AAO-HNSF 2022 Annual Meeting & OTO Experience in Philadelphia, Pennsylvania. The top three proposals selected will present and compete at SIM Tank. Both events will be held Monday, September 12. For more information about the submission process and deadline, go to **https://www.entnet.org/simulation-activities/**. ■

Pictures from the 2021 Simulation Reception and Showcase at the AAO-HNSF 2021 Annual Meeting & OTO Experience in Los Angeles, California

SIM Tank first place winner Alexis Graham-Stephenson, MD, pictured second to left, with Kelly Malloy, MD, Chair of the AAO-HNSF Simulation Committee; Jeffrey P. Simons, MD, MMM, AAO-HNSF Coordinator for Education; and Ken Yanagisawa, MD, AAO-HNS/F President-elect at the time of the event.

From left to right, Alexis Graham-Stephenson, MD, Sadia T. Ahmed, MD, and Clare Richardson, MD, taking first, second, and third respectively in the 2021 SIM Tank Showcase.

CPG

CLINICAL PRACTICE GUIDELINE

UPDATE! Tympanostomy Tubes in Children

Adapted from the February 2022 Supplement to *Otolaryngology–Head and Neck Surgery*. Read the CPG update at otojournal.org and find all supplemental materials at **www.entnet.org/CPGtymp-tubes-update**.

Insertion of tympanostomy tubes is the most common ambulatory surgery performed on children in the United States. The original guideline, published in 2013 and now with more than 500 citations, offered the first trustworthy recommendations on tympanostomy tube indications and subsequent research showed excellent adherence by clinicians to guideline recommendations for tube insertion and for watchful waiting to reduce unnecessary surgery. The AAO-HNSF guideline remains the only publication explicitly focused on tympanostomy tube indications and managing children who receive tubes.

"As the number one ambulatory surgery in children in the United States, insertion of tympanostomy (ear) tubes must be informed by trustworthy recommendations based on the best, and most current, research available, which is exactly what the new, fully updated CPG from AAO-HNSF accomplishes," said **Richard M. Rosenfeld, MD, MPH, MBA,** Chair of the Guideline Update Group (GUG). **David E. Tunkel, MD**, served as Assistant Chair and **Seth R. Schwartz, MD, MPH,** served as Methodologist.

The purpose of this CPG update is to reassess and update recommendations in the prior guideline and to provide clinicians evidence-based recommendations on patient selection and surgical indications for managing tympanostomy tubes in children.

"The bottom line is that tympanostomy tubes — inserted in the right child, for the right reason, and managed the right way — can offer children and families extraordinary benefits, which are best achieved by following the superb multidisciplinary guidance in this new update," said Dr. Rosenfeld.

In planning the content of the updated guideline, the GUG affirmed and included all the original key action statements (KASs) based on external review and GUG assessment of the original recommendations. The guideline update was supplemented with new research evidence and expanded profiles that addressed quality improvement and implementation issues. The group also discussed and prioritized the need for new recommendations based on gaps in the initial guideline or new evidence that would warrant and support KASs. The GUG further sought to bring greater coherence to the guideline recommendations by displaying relationships in a new flowchart to facilitate clinical decision making. Last, knowledge gaps were identified to guide future research.

"What is perhaps most exciting about the updated CPG is how it is part of a comprehensive suite of supporting materials that include an Executive Summary for clinicians, Plain Language Summary for patients and consumers, a flowchart that ties together all action statements in a cohesive management plan, an accompanying state-of-the-art review on in-office ear tubes and automated insertion devices, and a dedicated webpage with downloadable education materials for clinicians to use in shared decision-making with patients," said Dr. Rosenfeld.

This update, which includes new evidence from 27 randomized controlled trials, 18 systematic reviews, and six CPGs, is intended for any clinician involved in managing children aged six months to 12 years with tympanostomy tubes or being considered for tympanostomy tubes in any care setting as an intervention for otitis media of any type. This applies to all KASs unless otherwise specified.

The target audience includes specialists, primary care clinicians, and allied health professionals, as represented by this multidisciplinary GUG, which comprised the disciplines of otolaryngology-head and neck surgery, otology, pediatrics, audiology, anesthesiology, family medicine, advanced practice nursing, speech-language pathology, and consumer advocacy.

This update will undergo a planned review five years after publication or sooner if new evidence or developments might alter recommendations or suggest a need for additional guidance.

Guideline Update Key Action Statements

KAS 1: OME OF SHORT DURATION: (recommendation against)

Clinicians should not perform tympanostomy tube insertion in children with a single episode of OME of less than 3 months' duration, from the date of onset (if known) or from the date of diagnosis (if onset is unknown).

KAS 2: HEARING EVALUATION (recommendation)

Clinicians should obtain a hearing evaluation if OME persists for 3 months or longer OR prior to surgery when a child becomes a candidate for tympanostomy tube insertion.

KAS 3: CHRONIC BILATERAL OME WITH HEARING DIFFICULTY (recommendation)

Clinicians should offer bilateral tympanostomy tube insertion to children with bilateral OME for 3 months or longer AND documented hearing difficulties.

KAS 4: CHRONIC OME WITH SYMPTOMS (option)

Clinicians may perform tympanostomy tube insertion in children with unilateral or bilateral OME for 3 months or longer (chronic OME) AND symptoms that are likely attributable, all or in part, to OME that include, but are not limited to, balance (vestibular) problems, poor school performance, behavioral problems, ear discomfort, or reduced quality of life.

KAS 5: SURVEILLANCE OF CHRONIC OME (recommendation)

Clinicians should reevaluate, at 3- to 6-month intervals, children with chronic OME who do not receive tympanostomy tubes, until the effusion is no longer present, significant hearing loss is detected, or structural abnormalities of the tympanic membrane or middle ear are suspected.

KAS 6: RECURRENT AOM WITHOUT MEE (recommendation against)

Clinicians should not perform tympanostomy tube insertion in children with recurrent AOM who do not have MEE in either ear at the time of assessment for tube candidacy.

KAS 7: RECURRENT AOM WITH MEE (recommendation)

Clinicians should offer bilateral tympanostomy tube insertion in children with recurrent AOM who have unilateral or bilateral MEE at the time of assessment for tube candidacy.

KAS 8: AT-RISK CHILDREN (recommendation)

Clinicians should determine if a child with recurrent AOM or with OME of any duration is at increased risk for speech, language, or learning problems from otitis media because of baseline sensory, physical, cognitive, or behavioral factors.

KAS 9: TYMPANOSTOMY TUBES AND AT-RISK CHILDREN (recommendation)

Clinicians may perform tympanostomy tube insertion in at-risk children with unilateral or bilateral OME that is likely to persist as reflected by a type B (flat) tympanogram or a documented effusion for 3 months or longer.

KAS 10: LONG-TERM TUBES (recommendation against)

The clinician should not place long-term tubes as initial surgery for children who meet criteria for tube insertion unless there is a specific reason based on an anticipated need for prolonged middle ear ventilation beyond that of a short-term tube.

KAS 11: ADJUVANT ADENOIDECTOMY (option)

Clinicians may perform adenoidectomy as an adjunct to tympanostomy tube insertion for children with symptoms directly related to the adenoids (adenoid infection or nasal obstruction) OR in children aged 4 years or older to potentially reduce future incidence of recurrent otitis media or the need for repeat tube insertion.

KAS 12: PERIOPERATIVE EDUCATION (recommendation)

In the perioperative period, clinicians should educate caregivers of children with tympanostomy tubes regarding the expected duration of tube function, recommended follow up schedule, and detection of complications.

KAS13: PERIOPERATIVE EAR DROPS (recommendation against)

Clinicians should not routinely prescribe postoperative antibiotic ear drops after tympanostomy tube placement.

KAS 14: ACUTE TYMPANOSTOMY TUBE OTORRHEA (strong recommendation)

Clinicians should prescribe topical antibiotic ear drops only, without oral antibiotics, for children with uncomplicated acute tympanostomy tube otorrhea.

KAS 15: WATER PRECAUTIONS (recommendation against)

Clinicians should not encourage routine, prophylactic water precautions (use of earplugs or headbands, avoidance of swimming or water sports) for children with tympanostomy tubes.

KAS 16: FOLLOW-UP (strong recommendation)

The surgeon or designee should examine the ears of a child within 3 months of tympanostomy tube insertion AND should educate families regarding the need for routine, periodic follow-up to examine the ears until the tubes extrude.

In developing this update, the methods listed in the AAO-HNSF "Clinical Practice Guideline Development Manual, Third Edition" were followed explicitly. **https://journals.sagepub.com/doi/full/10.1177/0194599812467004**

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

Guideline authors:
Richard M. Rosenfeld, MD, MPH, MBA (Chair)
David E. Tunkel, MD (Assistant Chair)
Seth R. Schwartz, MD, MPH, (Methodologist)
Samantha Anne, MD
Charles E. Bishop, Au.D., Ph.D., CCC-A
Daniel C. Chelius, Jr., MD
Jesse Hackell, MD
Lisa L. Hunter, PhD
Kristina L. Keppel, DNP, RN, APNP
Ana H. Kim, MD
Tae W. Kim, MD
Jack M. Levine, MD
Matthew T. Maksimoski, MD
Denee J. Moore, MD
Diego A. Preciado, MD, PhD
Nikhila P. Raol, MD, MPH
William K. Vaughan
Elizabeth A. Walker, PhD, CCC-A/SLP

Accompanying Resources to the CPG Update:

- Plain Language Summary
- Executive Summary
- Slide deck
- Podcasts
- Patient handouts (in both English and Spanish)
- Official quick-reference pocket guide and app

Access all these resources and more at **www.entnet.org/CPGtymp-tubes-update**.

Endorsed by:
American Academy of Audiology (AAA); International Society for Otitis Media (ISOM); Society for Pediatric Anesthesia (SPA); Society of Otorhinolaryngology Head-Neck Nurses (SOHN)

Supported by:
American Speech-Language-Hearing Association (ASHA)

Disclaimer:
The clinical practice guideline is provided for information and educational purposes only. It is not intended as a sole source of guidance in managing children with tympanostomy tubes or being considered for tympanostomy tubes. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. The guideline is not intended to replace clinical judgment or establish a protocol for all individuals with this condition and may not provide the only appropriate approach to diagnosing and managing this program of care. As medical knowledge expands and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions but are not absolute. Guidelines are not mandates; these do not and should not purport to be a legal standard of care. The responsible physician, in light of all circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNSF emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results.

"The bottom line is that tympanostomy tubes — inserted in the right child, for the right reason, and managed the right way — can offer children and families extraordinary benefits, which are best achieved by following the superb multidisciplinary guidance in this new update."

– Richard M. Rosenfeld, MD, MPH, MBA

CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

EAR TUBES - A CAREGIVER'S GUIDE

WHY ARE EAR TUBES RECOMMENDED?

Ear tubes are recommended for frequent ear infections or prolonged fluid in the ears. They will:

- Help decrease the number of ear infections
- Allow any future ear infections to be treated with antibiotic ear drops instead of antibiotics that are taken by mouth
- Help prevent fluid from backing up into the area behind the eardrum (middle ear)
- Improve hearing that is decreased because of fluid in the middle ear

HOW LONG WILL MY CHILD'S EAR TUBES LAST?

Most ear tubes last about 6 to 18 months. By the time the tube comes out about 80% of children will have much better ear function and will not need to have the tube replaced.

WHEN DOES MY CHILD NEED TO BE SEEN AGAIN AFTER THE TUBES ARE PLACED?

- After Surgery: We will see your child within 3 months to make sure that the ear tubes are in place and working. We often check your child's hearing at that visit.
- Ongoing Follow-Up: After this first visit, we should see your child regularly, usually every 6 months, while the tubes are in the ears to make sure that the tubes are working and to check for any possible problems, as discussed in the next section. Keep in mind that regular follow-up visits are important, even if your child has no obvious issues with ears or hearing, to prevent problems.
- Final Visit: Once the tubes fall out, your child should return after 6-12 months so your ear, nose, and throat doctor or other health care provider can check the ears to make sure they are healthy.

WHAT ARE THE POSSIBLE COMPLICATIONS, OR PROBLEMS, OF EAR TUBES?

- *Scarring.* A white mark from scarring (sclerosis) or a small depression or pocket may be seen on the eardrum, but this usually does not affect hearing or cause infections and is usually of no concern.
- *Perforation.* About 1-2 out of every 100 children will still have a hole (perforation) in the eardrum after a short-term tube falls out, with up to 1 in every 5 children having a perforation after a long-term tube. The hole will often close on its own, but if it does not, it can be repaired in the operating room as a day surgery procedure.
- *Tubes falling in.* Tubes almost always fall out of the eardrum into the ear canal. Very rarely a tube can fall into the middle ear, but usually does not cause any problem and can be removed, if needed.
- *Tubes not coming out.* Most tubes come out within 12 to 24 months. If the tube is still in after 2 to 3 years, or longer, it can be removed.
- *Tube coming out too early.* In rare cases the tube may fall out before 6 months, but many children will have improved by that time. For those who continue to get ear fluid or frequent ear infections a tube may need to be replaced.

DOES MY CHILD NEED EAR PLUGS WHEN EXPOSED TO WATER?

Your child will not usually need ear plugs for swimming and bathing while the tubes are in place and open. Head bands or other special efforts to keep water from entering the ear canal are also unnecessary, but may be helpful in the following situations:

- Pain or discomfort when water enters the ear canal
- Current fluid or drainage from the ear canal (an ear infection with the tube), or your child has had frequent drainage
- Swimming in lakes or non-chlorinated pools that are not clean
- Dunking head in the bathtub (soapy water passes through the tiny hole in the tube easier than plain water)

There are several types of soft ear plugs or ear putty available, as well as neoprene headbands to cover the ears. NEVER use Play-Doh or Silly Putty as an ear plug—these materials can become trapped in the ear canal and even require surgical removal.

EAR TUBES AND EAR INFECTIONS

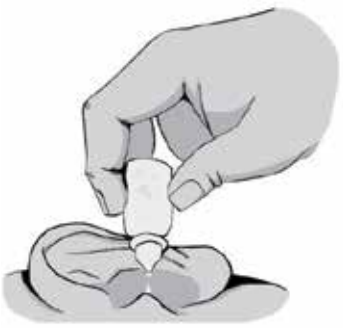
Ear tubes will help decrease the number of ear infections, but your child may still get an ear infection when he or she has ear tubes. When the tube is open and working, you may see drainage at the opening of the ear canal. Before ear tubes, this drainage would stay in the middle ear, trapped behind the eardrum, unless the pressure caused the eardrum to burst or rupture. Now that the tube makes an opening in the eardrum, drainage will come through the ear tube into the ear canal.

Drainage can be thin, thick, cloudy, yellow, or green, and even bloody. Most children do not typically have fever or pain when they have ear drainage with tubes in place.

If you see drainage from the ear, we recommend the following:

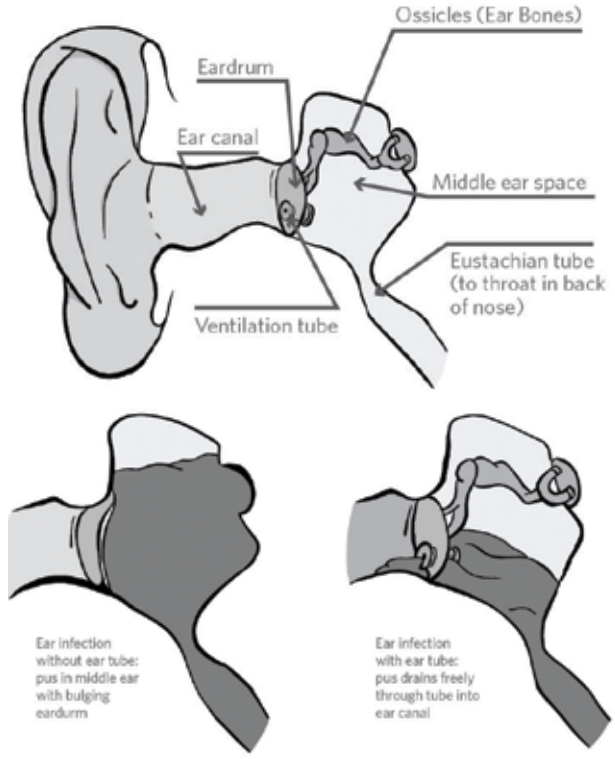
1. Antibiotic ear drops, without oral antibiotics, are all that is needed in most cases (usually ofloxacin or ciprofloxacin-dexamethasone). Do NOT use over the counter ear drops.
2. Ear drainage may build up or dry at the opening of the ear canal. Remove the crusting with a cotton-tipped swab dipped in hydrogen peroxide or warm water. If the drainage is thick, you can also roll up a piece of tissue or toilet paper to help soak up the drainage out before you use ear drops.
3. Do not swim during infections when there is drainage or discharge coming from the ear. During bathing, use silicone ear plugs, or coat a small cotton ball with petroleum jelly and use it to cover the opening of the ear canal.
4. Use the ear drops only for the amount of time recommended by your doctor, because using them too long could result in a yeast infection.
5. Antibiotics taken by mouth are not needed for most ear drainage with tubes in place. Sometimes they may be needed if your child has another reason to be on an antibiotic, or the infection does not go away after using only ear drops.

When using ear drops, do the following to help pump the drops in the ear canal and get down to the ear tube:



1. Have your child lay down on their side. Put ear drops into opening of ear canal.

2. Push down on tragus 4-5 times (small piece of cartilage in front of ear canal opening). This will help pump the drops into the canal.



What are possible reasons why my doctor or health care provider may diagnose an ear infection when we haven't seen drainage yet?

1. The tube is open and drainage has started but is not yet seen at the ear canal opening. This suggests an early stage of infection for which antibiotic ear drops will help it go away quickly.
2. The tube is not working or is blocked, so the ear infection is treated as if the tube was not there. This is a time when antibiotics by mouth may be needed. The blocked tube does not do any harm (and will not cause a problem), but it also will not drain the infection. Use acetaminophen or ibuprofen for pain.
3. The tube is open but there is no drainage in the tube opening or ear canal. In this case no special treatment is necessary, even if the eardrum appears red or irritated, which can occur when your child cries or has fever without an ear infection.

When to Call the Ear Doctor (Otolaryngologist):

1. Your child's regular doctor or health care provider can't see the tube in the ear, or the tube is blocked.
2. Your child has a hearing loss, continued ear infections or continued ear pain/discomfort.
3. Ear drainage continues for more than 7-10 days without improvement with treatment.
4. Drainage from the ear occurs frequently or more than you think should happen.
5. There is wax build-up in the ear canal that doesn't allow the tube to be seen.

SOURCE: Rosenfeld RM, Tunkel DE, Schwartz SR, et al. Clinical Practice Guideline: Tympanostomy Tubes in Children (Update). *Otolaryngol Head Neck Surg*.2022;166(1_suppl):S1-S55.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION®

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ABOUT THE AAO-HNS/F

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

CLINICAL PRACTICE GUIDELINES

PATIENT INFORMATION

What should I do if my child has frequent ear infections but no persistent fluid (effusion) behind the eardrum in the middle ear?

Why am I receiving this information sheet?

You are receiving this information sheet because your doctor has not recommended ear tubes for your child, even though they have had frequent ear infections in the past and may have been referred to the specialist specifically for ear tube surgery. The information that follows will clarify why it is in your child's best interest to hold off on ear tubes for now, recognizing that this decision could change if your child continues to suffer from frequent ear infections.

What is middle ear fluid, also called effusion?

When a child has acute otitis media or an ear infection, they have fluid and germs in their middle ear, behind the eardrum. Middle ear fluid is also called an effusion, which is typically cloudy and full of bacteria and white blood cells in the worst part of the ear infection. We call this a purulent effusion, commonly known as pus. As the ear infection goes away the effusion is absorbed by the body or drains through the eustachian tube, a connection in the skull between the ear and back of the nose. This process can take several weeks, but within 3 months about 90% of children no longer have middle ear fluid. So, it would be perfectly normal for a child to have an effusion when an ear infection is first diagnosed but they may not have a persistent effusion when they are examined days or weeks later.

What does it mean if my child has repeated ear infections, but doesn't have middle ear fluid (effusion) when they are seen by an otolaryngologist (ear, nose, and throat doctor)?

For most children, if their effusions completely clear up between their last infection and the time they are seen in a surgeon's office, it means that their eustachian tubes work well. Even if these children meet the definition of having had frequent ear infections (3 or more in the past 6 months, or 4 in the past 12 months), we know from research studies that nearly half will not have more ear infections and only about 1 in 3 will continue to have frequent infections. Other research shows that 2 out of every 3 children who see an otolaryngologist for repeated ear infections, but who have a normal examination (no middle ear fluid) in the office, do not require ear tubes in the future. If your child, however, continues to have frequent ear infections, they should be reevaluated by the otolaryngologist and may qualify for ear tubes in the future.

Are there any children who should still get ear tubes for recurrent infections even without an effusion on the day of their examination by the otolaryngologist?

Yes, there are some exceptions. If any of the following apply to your child, you should discuss with your doctor whether ear tubes may still be of benefit:

- Weak immune system or other problems putting them at higher risk for infections
- Prior complications of ear infections including seizures (from high fever) or infections spreading to the neck, bone behind the ear, or the brain
- Adverse antibiotic reactions, allergies, or inability to take oral antibiotics that make it difficult to treat ear infections when antibiotics are needed
- High risk of developmental problems including permanent hearing loss, delays in speech or language, delays in learning, autism-spectrum disorder, syndromes (e.g., Down) or structural problems with the face and head (e.g., cleft palate), or severe vision loss

What if my family doctor specifically sent me to the otolaryngologist for the purpose of getting ear tubes, but there is no middle ear fluid and the doctor wishes to wait before surgery?

Although your child may have had a tough time with frequent ear infections in the past, the real question is whether inserting ear tubes will help them by reducing future ear infections. The best research evidence we have suggests that inserting tubes will not reduce future ear infections when there is no persistent effusion, but the procedure does involve some minor risks related to the ear tube and general anesthesia. Waiting a bit more to see how your child does on their own does not carry any risk or harm, since many children will not have any further ear infections at all and most will never need tubes. As noted previously, if your child continues to have ear infections they can be reevaluated and tubes can be arranged at that time if middle ear fluid is present.

SOURCE: Rosenfeld RM, Tunkel DE, Schwartz SR, et al. Clinical Practice Guideline: Tympanostomy Tubes in Children (Update). *Otolaryngol Head Neck Surg*.2022;166(1_suppl):S1-S55.

AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY FOUNDATION®

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ABOUT THE AAO-HNS/F

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

FROM THE EDUCATION COMMITTEES

Management of Pediatric Thyroid Nodules

Meredith Merz Lind, MD, Chair, Pediatric Otolaryngology Education Committee

While less common in children than adults, thyroid nodules are present in 1%-5% of people under 18 years of age. Additionally, pediatric thyroid nodules are more likely to be malignant, with 22%-26% of them cancerous, compared to about 5% in adult patients.[1] New cases of thyroid cancer in pediatric patients also appear to be increasing in the United States, with thyroid carcinoma now the second most common cancer seen in girls.

Papillary thyroid carcinoma is by far the most common subtype of differentiated thyroid cancer, representing about 90% of cases. Pediatric patients are more likely to have multifocal and locoregional disease at presentation, and younger patients are more likely to have persistent disease or recurrence. Given the different risks, outcomes, and goals of therapy in children, a pediatric-specific clinical practice guideline was developed and published by the American Thyroid Association in 2015.[2]

Many guidelines for evaluation of thyroid nodules in children are similar to those in adults; however, there are a few recommendations that differ. Included here is the recommendation that clinical context, including genetic conditions or history that increases the risk of thyroid carcinoma, and ultrasound characteristics, such as hypoechogenicity, irregular margins, increased blood flow, microcalcifications, and abnormal cervical lymph nodes, are considered in the decision to obtain a fine needle aspiration (FNA) biopsy of a dominant thyroid nodule.

It is also recommended that all FNA performed in children be done with ultrasound guidance and that surgery (total thyroid lobectomy with isthmusectomy) is favored over repeat FNA in children with nondiagnostic FNA. Surgery is also recommended for nodules > 4 cm in size, even with benign pathology, due to a high false-negative rate in FNA in these nodules. Finally, it is recommended that thyroid scintigraphy be performed in the case of a thyroid nodule associated with suppressed thyroid stimulating hormone and that nodules confirmed to be autonomously functioning ("hot nodules") be treated with surgery, as long-term effects of medical treatment options are not well understood in pediatric patients.[2]

When differentiated thyroid carcinoma (DTC) is identified in a pediatric patient, a comprehensive neck ultrasound is required to help identify locoregional metastases and optimize surgical planning.[1] Additional imaging with computed tomography or magnetic resonance imaging may also be considered in certain clinical scenarios. Total thyroidectomy is recommended for most pediatric patients with DTC. This is due to the increased risk of bilateral disease and decreased risk of local recurrence when bilateral surgery is performed. Central neck dissection is recommended in patients with clinical evidence of extrathyroidal invasion or gross lymph node disease and should be considered for all patients with DTC to help direct the need for additional therapy. Routine lateral neck dissection and berry picking are not recommended; however, lateral neck dissection should be performed in patients with confirmed lateral neck disease. Measurement of intact parathyroid hormone in the immediate postoperative setting can help to identify those patients at risk of developing hypocalcemia and allows for early treatment with calcium and calcitriol.[2]

It is recommended that pediatric thyroid surgery be performed only in hospitals with the full spectrum pediatric care, including a high-volume thyroid surgeon, pediatric endocrinologist, anesthesiologist, intensive care, radiation therapist, and radiologist. These characteristics are associated with lower complications, decreased hospital stay, and lower costs.[2] Treatment by multidisciplinary teams of experts has also been shown to optimize postoperative treatment and monitoring by balancing risks and benefits. For more detailed information about the evaluation and management of pediatric thyroid nodules and differentiated thyroid cancer, please refer to the eCourse in OTO Logic that reviews this topic in depth. ■

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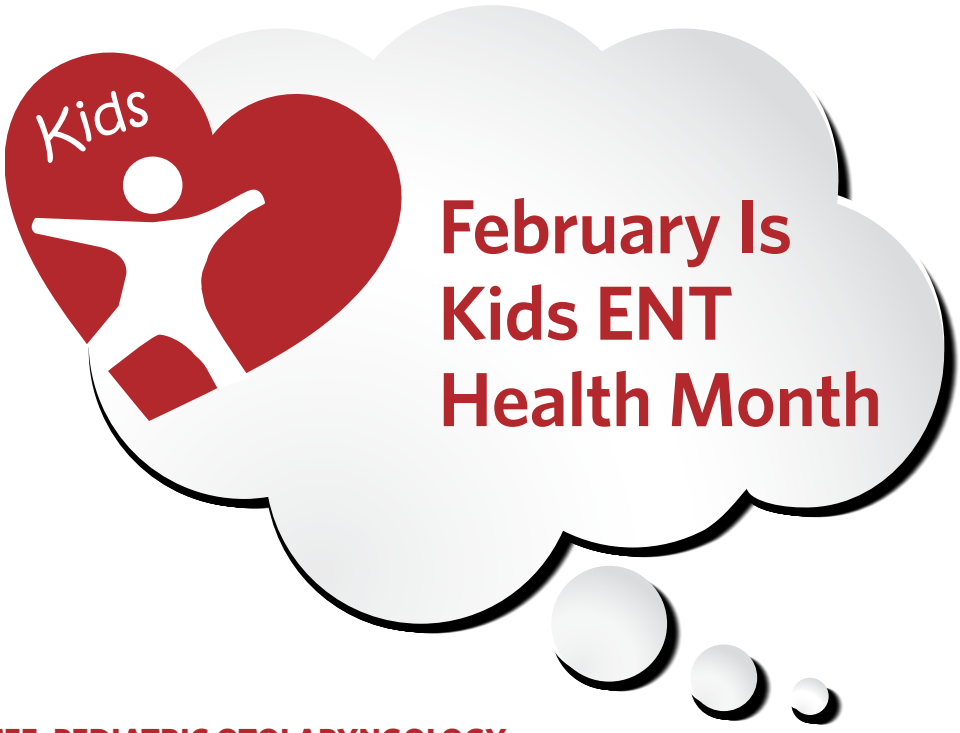

OUT OF COMMITTEE: PEDIATRIC OTOLARYNGOLOGY

COVID-19 in Children: Severity, Sequelae, and Vaccine Update

James M. Ruda, MD, Committee Chair-elect
Mathieu Bergeron, MD, Committee member
Heather C. Herrington, MD, Committee Chair

Note: This article includes data current at the date of publication.

Since early 2019, the world has witnessed the rise of a novel coronavirus (COVID-19) that has culminated into a global pandemic. Within the United States, the first case of COVID-19 was initially reported by the Centers for Disease Control and Prevention on January 20, 2020, in the state of Washington.[1]

From the start of the pandemic to the time this article was published, the U.S. population alone has experienced 51,500,000 cases of COVID-19, equating to an infection rate of 15.6% of the U.S. population in <2 years. When considering minimally or asymptomatic Americans (potentially untested for COVID-19), it is estimated that 103,000,000 (one in three) Americans may have been infected with the SARS-CoV-2 virus before the end of 2021. Tragically, this is well before the advent of the Delta virus strain or Omicron strain, both of which are currently circulating within the U.S. Overall, approximately 860,000 Americans have died from COVID-19 since the pandemic began.[2] Globally, COVID-19 is thought to have infected over 252,000,000 people and resulted in 5.11 million deaths, with the U.S. leading in COVID-19 deaths worldwide.[3]

COVID-19 symptoms commonly include respiratory symptoms such as dry or productive cough, shortness of breath, fevers, chills, fatigue, rhinorrhea, muscle and body aches, sore throat, headache, and new loss of taste or smell. Some people may present with primarily gastrointestinal (GI) symptoms such as nausea, vomiting, and diarrhea prior to lower respiratory tract symptoms.

In most individuals, acute COVID-19 symptoms appear 2-14 days after exposure and often improve within 14 days.[4] Rarely, long-term symptoms lasting greater than 3-6 months following COVID-19 infection (i.e., long COVID) have been found to persist in approximately 33%-50% of individuals.[5,6]

Compared to adults, children often have milder COVID-19 symptoms that can mimic the "common cold," or they may even have no symptoms at all. Although children may have few symptoms, their viral loads can be as high as symptomatic adults with COVID-19, and children can spread the disease. COVID-19 can also infect infants and neonates, and like other viruses, it can cause more symptoms in this age group because of their small airways.

Overall, U.S. children have been reported to represent about 17.3% of all COVID-19 cases nationally, although this proportion is continuing to rise with the spread of the Delta and Omicron COVID-19 strains.[7] Children most at risk for severe illness from COVID-19 include those with other health conditions such as obesity, diabetes, asthma, congenital heart disease, genetic conditions, or conditions affecting the nervous system or metabolism. Currently there is much speculation about why children contract COVID-19 less frequently and symptomatically than adults. Many theories revolve around the suspicion that children are afforded more baseline overlapping protection against COVID-19 given their frequent exposure to similar non-SARS-CoV-2 or respiratory viruses encountered during childhood. Other theories involve potentially a less mature immune system, differential expression of pulmonary angiotensin-converting enzyme receptors to which the virus binds, and children's different

COVID-19 Age Group

Updated Nov. 22, 2021

National Center For Health Statistics. Centers For Disease Control. Available at: **https://www.cdc.gov/nchs/covid19/**

Rate compared to 18-29 years old	0-4	5-17	18-29	30-39	40-49	50-64	65-74	75-84	85+
Cases	<1x	1x	Reference group	1x	1x	1x	1x	1x	1x
Hospitalization	<1x	<1x	Reference group	2x	2x	4x	5x	8x	10x
Death	<1x	<1x	Reference group	4x	10x	25x	65x	150x	370x

systemic reaction to the SARS-CoV-2 virus.[7]

In children, a rare but serious late complication of COVID-19 infection is the development of MIS-C (multisystem inflammatory syndrome in children). MIS-C causes inflammation that can affect the heart and lungs, blood vessels, kidneys, digestive system, brain, skin, and eyes, and can occur about two to six weeks after infection. Treatment involves quick recognition, hospitalization, and management with intravenous immunoglobulin, steroids, and nonsteroidal anti-inflammatory drugs.

We do not yet understand what triggers some children with prior COVID-19 infection to develop MIS-C.[8] Frequent signs and symptoms of MIS-C include fever, GI symptoms, tachycardia/tachypnea, tiredness, redness of the hands/feet, swelling, and redness of the lips and tongue. If a child develops these symptoms, particularly after a known COVID-19 infection or exposure, they should be evaluated immediately. A large ratio of children with MIS-C may require intensive care because of low blood pressure, but often this is not fatal.

Children are protected from COVID-19 infection in much the same way as adults. Social distancing, masking, frequent handwashing, and vaccination are the best ways to protect children and vulnerable individuals from COVID-19 infection. In children who are too young to be vaccinated, ensuring that those around them are vaccinated and practice the above precautions is the best way to protect this vulnerable population. While initially there was some concern that vaccination may put children—particularly boys—at higher risk for side effects from COVID-19, we now know that the risk of side effects, such as myocarditis, with vaccination is low and treatable with simple interventions such as ibuprofen (Advil) administration.[9]

One of the most common ENT manifestations of COVID-19 infection is loss of smell. Other manifestations of COVID-19 include facial palsy or sudden hearing loss that have been reported in adults and very rarely in children.[4] Loss of taste and smell after COVID-19 infection is a common complaint and can affect ~50% of individuals infected. It is thought that loss of smell results from infection of the sustentacular cells (supportive cells) around the olfactory neurons that are responsible for one's sense of smell. Both the olfactory neurons and the surrounding sustentacular cells are located within the uppermost regions of both nasal cavities. As SARS-CoV-2 virus is a respiratory virus, infection by the SARS-CoV-2 virus occurs from breathing it into the body, often through the nose. The SARS-CoV-2 virus primarily targets the sustentacular cells and olfactory neurons to cause infection. When exposed to the SARS-CoV-2 virus, the sustentacular cells are primarily targeted and destroyed by the SARS-CoV-2 virus and the body's immune response to it. These cells may take two to four weeks to start to regenerate from precursor cells, i.e., stem cells, within the area of the olfactory nerves. Hence, in many individuals after COVID-19 infection, it may take about one to six months for many individuals' sense of taste and smell to improve. In a small minority of patients, return of taste and smell may never occur. While many medications are often tried to help recover patients' loss of taste and smell after COVID-19 infection, none are frequently effective. In individuals with prolonged loss of taste and smell after COVID-19 infection or who develop new phantom/abnormal smells or tastes, practicing "smell therapy" can be helpful to retrain and reeducate the body to familiar tastes and scents.

Within the pediatric population, protection from COVID-19 infection over the past two years has included similar strategies to those practiced by adults. This has included social distancing in public settings, frequent handwashing, and masking when unable to socially distance. Since December 11, 2020, vaccination of older children with Pfizer-BioNTech and Moderna has occurred, with expansion to children 5-11 years old beginning October 29, 2021. With current uncertainty regarding the Omicron variant and its potential transmissibility to children, the best line of defense against infection from all strains of COVID-19 still involves vaccination of all eligible children and adults in the U.S., in addition to continued attention to social distancing, masking, and frequent handwashing. ■

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How to Recognize

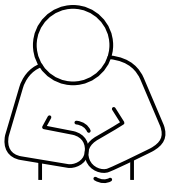
Multisystem Inflammatory Syndrome in Children (MIS-C)

A Delayed Immune Response Related to COVID-19

Children, adolescents, or young adults who develop certain symptoms after having COVID-19 might have MIS-C. They should see a doctor if they had COVID-19, or have been in close contact with someone who had COVID-19, within the past 6 weeks and now have the following:

Ongoing Fever

PLUS more than one of the following:



Stomach Pain

Diarrhea

Vomiting

Skin Rash

Blood Shot Eyes

Dizziness or Lightheadedness

Go to the nearest hospital Emergency Room if your child is showing any severe MIS-C warning signs such as:

Trouble breathing | Pain or pressure in the chest that does not go away
Confusion or unusual behavior | Severe abdominal pain | Inability to wake or stay awake
Pale, gray, or blue-colored skin, lips, or nail beds; depending on skin tone

Centers for Disease Control and Prevention
National Center for Immunization and Respiratory Diseases

For More Information
www.cdc.gov/mis/mis-c.html

Handout prepared by the U.S. Centers for Disease Control and Prevention.

FROM THE EDUCATION COMMITTEES

How Is Your Time Valued?

Your time is precious, and many would agree that time is your most valuable asset. There are many lenses through which to view the value of your time. Some view this valuation purely economically and use a variety of methodologies to calculate the value—examples include the Cost-Based Method, which is the rate you would pay someone else to do the work that you do; the Market Rate Method, which is the rate you could expect to earn if another entity hired you for the same job; and the Expected Value Method, which bases calculations on the value you expect current time spent to create in the future.

Others see time value in a less mathematical sense and consider its worth in the context of happiness and meaning, adding in factors like how much happiness or meaning a task adds to your life. Some frame time as it relates to their potential professional work years, their "healthy years," or the years they can spend with their children or other loved ones. These measurements are unquestionably just estimates, as we never really know how much time we will have our health or in our lives or the lives of loved ones. Values, opportunity costs, and the many ways people personally define work, distractions, joy, and worth all affect these assessments. This article from the Practice Management Education Committee will focus on a more narrow, specific, and tangible way your time is valued for you as a physician in the context of our current medical reimbursement system, the black box of Current Procedural Terminology (CPT) valuation. To give some historical context, recall that in 1992 Medicare significantly changed the way it pays for physician services. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a Resource-Based Relative Value Scale (RBRVS). As part of the creation of the RBRVS in 1992, CPT codes, which were first published in 1966 by the AMA, were assigned values theoretically based on the principle that payments for physician services should vary with the resource costs for providing those services.

The AMA works with national medical specialty societies to recommend CPT code values, updates, and changes to the Centers for Medicare & Medicaid Services (CMS). The vehicle for this process is the multispecialty AMA/Specialty Society RVS Update Committee (RUC), which provides annual relative value recommendations to CMS. It should be emphasized that these are only recommendations. CMS assigns actual CPT values, as well as updates on payment policies, payment rates, and other provisions for Medicare services, through annual rulemaking on the Medicare Physician Fee Schedule. Medicare's payment decisions for individual CPT codes are also the basis for many public and private third-party payer contracts.

In this RBRVS system, payments are determined by the resource costs needed to provide them, with each service divided into three weighted components (shown in parentheses): Physician work (50.9%), practice expense (44.8%), and professional liability insurance (4.3%). Your time is the physician work component, which is assigned a particular value in terms of RVUs and also minutes. The factors used to determine physician work include: 1) the time it takes to perform the service, 2) the technical skill and physical effort, and 3) the required mental effort and judgment and stress due to the potential risk to the patient. The RUC Panel that assigns these values for your time and work reportedly represents the entire medical profession, with 22 of its 32 members appointed by major national medical specialty societies, including the AAO-HNS. These individual RUC members are charged with exercising their independent judgment and cannot openly advocate for their respective specialties. The advocate role is delegated to separate advisors from each of the specialties who present recommendations to the RUC regarding CPT codes that pertain to their respective specialty.

So, where are these times and perceived efforts used to assign RVUs derived from? They come from the physicians themselves in the form of CPT valuation surveys. To establish value recommendations, the times reported by the few Academy members who actually complete these surveys are collated and presented to the RUC by the Academy's physician advisors. Admittedly, these surveys are lengthy and often cumbersome. This is primarily because there are strict rules from the AMA on how these standardized survey instruments can be presented to the society membership. Despite the inherent challenges, it is from these few returned surveys that the work you perform is assigned time, valued, and ultimately paid. Though nuanced and often appearing imperfect and veiled, this is the process by which the many hours that physicians spend their clinical time is assigned a monetary value. Fortunately, the real value of what we do for our patients and communities, and the fulfillment that we receive from our privilege to serve them, is truly priceless. ■

Tech Talk

Desktop-as-a-Service

Mike Robey, MS, AAO-HNS/F Senior Director, Information Technology

Cloud computing has ushered in the era of Anything-as-a-Service. Whether you are looking for application software, an integrated platform, or infrastructure solutions, chances are you can find it in the cloud. With the July 2021 announcement of Windows 365, Microsoft has thrown its hat in the ring as a Desktop-as-a-Service provider. This article explains what this service is, along with some thought-provoking pros and cons.

For background purposes, below are definitions of four common cloud-based service offerings:

Infrastructure-as-a-Service (IaaS): Instead of physical, on-premises machines, servers are in the cloud. Your IT staff is still responsible for maintaining the operating system and applications. Data is stored within the enclave of the IaaS provider.

Platform-as-a-Service (PaaS): The cloud provider gives you an environment where you can develop workflows and configure applications to your needs. The provider maintains the software environment. Data is stored within the enclave of the PaaS provider.

Software as a Service (SaaS): The cloud provider gives you access to their software application. They maintain the software. Data used by the application resides within the SaaS enclave.

Desktop as a Service (DaaS): The provider gives you a virtual desktop. Your IT staff installs the business and office productivity software used by your practice. Data may reside in multiple places depending on the software installed on the virtual desktops. For instance, documents produced using the virtual desktop may reside in the DaaS enclave. Data used by the business applications may reside elsewhere.

Here is how DaaS works. The virtual desktop is streamed over the internet to the user's preferred device. Functionally it makes no difference if the preferred device is a computer in the office, smartphone, tablet, or home computer. The big advantage is because the virtual desktop resides in the cloud, the user can suspend activity and pick things up right where they left off. For example, if the user leaves the office, they can suspend and disconnect from their virtual desktop. Later, the virtual desktop session can be resumed at the point where it was suspended.

From an administrator's perspective, deploying and decommissioning virtual desktops is faster than dealing with physical computers. More importantly, patching and updating are centralized and simplified. It is much easier and faster to deploy a security patch to a fleet of virtual desktops than physical machines. No more worries about spilled water ruining a user's computer or a laptop getting left behind in a taxi. Administrators might even consider provisioning staff with less expensive Chromebooks or extending the regular computer replacement schedule for new computers. All this sounds great but there are some drawbacks.

DaaS is not meant for intense data processing. The jury is out as to how well virtual desktops perform with huge spreadsheets. Dual monitor support may only be available if connected through a physical Windows machine. Zoom and other video conferencing calls might not work as efficiently on virtual desktops.

There are some additional unknowns. Will the DaaS provider allow you to install third-party programs? And will these applications work on the virtual desktop? Will office printers and scanners work with the virtual desktops?

There are other competing services—Citrix and Amazon Workspaces, to name a couple. Consulting with your IT department or managed services provider is advisable before moving forward. A total cost of ownership analysis is a good place to start. The per seat cost of DaaS might seem high but if this leads to cost savings in other areas, such as end user devices, reduction in support costs (software patching and updates), security, and productivity gains, further investigation of DaaS may be worthwhile. Another possibility is to use DaaS for very specific use cases. As an example, the Academy has used virtual desktops for years to support the Annual Meeting. Whatever your identified use case is, make sure you know where your data and documents are stored. ■

Going (or Going Back) into Practice: What to Expect

Starting a practice, taking a new position, or transitioning to a different practice type or location is a daunting proposition, and one that our professional training doesn't necessarily prepare us for. Many practice management decisions we have to make are outside our expertise and comfort zone. Some preparation, organization, and perseverance can go a long way to reduce anxiety and foster a successful quest. Whether you plan to go into private practice, group practice, or academic medicine, these 10 steps will help you navigate your practice transition and build a rewarding career in otolaryngology.

Top 10 To-Do List for Going into Practice 2022

☐ 1. Plan Ahead

Think about your professional goals, values, and vision: What would you like your career to look like in five years, in 10 years? Determine your comfort level with risk, and then examine each practice type to determine the real risk involved. Starting a solo practice might seem riskier than taking employment with a health system, but there are risk factors associated with an employed or tenure track position as well. Create a timeline for your transition and start planning early in the process. Make a list of checkpoints and deadlines to help move the process along. You may not always be able to follow the plan exactly but envisioning what the search should look like is very helpful.

☐ 2. Find a Mentor

Look for shadowing opportunities in a practice setting that you think you might enjoy. Talk to colleagues from residency who are in practice and find out their likes and dislikes. A mentor can help you set and achieve goals, hold you accountable and provide trusted answers, act as a sounding board, and give practical advice and insight that will improve your chances of finding the right fit for you.

☐ 3. Assemble an Idea Book

Collect examples of best practices in your current position: Forms, policies, and procedures; instruments lists and clinical supplies; patient surveys and welcome letters; marketing materials, patient education, and communication tools; and coding and billing resources.

☐ 4. Find the Right Community

Research professional demographics: Is the region saturated with your specialty because it is near a training center? Or, is it an underserved area with a paucity of specialists? Study the major health systems in the area and speak to providers in that system if possible to gauge their job satisfaction level. What are the predominant referral networks for specialists, and how would your practice fit in? Compare the regional cost of living versus salary and benefit packages in the area. Several organizations release yearly salary and benefits comparisons to get a general idea of compensation in a particular state or region. Talk to colleagues who have settled in your region of interest and ask how they feel about earnings versus expenses. Will your partner and/or family be happy here? The best practice opportunity is often a blend of professional opportunity and optimized personal life.

☐ 5. Find the Right Practice Type

Do you hope for an academic appointment after a fellowship? Are you excited to practice comprehensive otolaryngology as a community provider? A hybrid of both? Employed by a health system or owner/partner in a private practice? Do you prefer a large or small group? Full-time or part-time? Some physicians in transition choose a temporary locum tenens assignment to test drive a location or practice.

☐ 6. Find Your Practice

Once you've done your background work, start asking more specific questions: What is the salary or productivity plan? What is the call and hospital rounds arrangement? Is there a signing bonus or a buy-in contract? What is the governance structure or tenure track plan? How much flexibility does the schedule allow? What is the reputation of the clinic or department in the community and within your specialty? Does the corporate culture align with your goals and values?

There are many options for Otolaryngologists, and one of them is just right for you. Make your plan, gather your team, and enjoy a fulfilling and rewarding career in your new practice!

7. Assemble Your Team

Get as much input as possible from your partner and family. A healthcare attorney can be very helpful to review contracts, productivity plans, noncompete clauses, and other legal matters. A recruiter or locum agency, if appropriate, can be very helpful in some cases. A realtor who knows the local housing market is very important, as is a financial planner and/or an accountant.

8. Get Involved

Once you have settled on a practice, get involved with physicians locally and nationally. The AAO-HNS has the Young Physicians Section, Women In Otolaryngology Section, and the brand-new Private Practice Study Group. In addition, there are many Academy committees and Board of Governors committees to join. Become active with your state otolaryngology-head and neck surgery society, the American Medical Association, your state medical society, your medical school and residency alumni organization, your hospital's medical staff committees, your clinic, or department governance boards. Attend meetings and network!

9. Learn Basic Practice Management

Even if you have an administrator, clinic manager, financial officer, or department chair, it pays to understand how your business office functions. Correct coding requires more than just a passing knowledge of CPT and ICD-10 codes. Financial management, performance metrics and dashboards, marketing and reputation management, quality and patient safety reporting, and alternative payment models are the future of clinical practice. If you're not at the table, you may be on the menu!

10. Build a Winning Team

Get to know your office and operating room staff well, benefit from their experience and knowledge, and build mutual trust and respect. Offer and take honest, constructive feedback to strengthen relationships and streamline best practices. Catch them in the act of doing good work, and reward excellence. Pay attention to their needs, listen attentively, and model flexibility and courtesy. Promote teamwork and synergy and make it your job to find and fix any dissatisfiers. Your staff and support team can make your practice a paradise, or, well, you know… ■

Resources:

10 tips for Transitioning into Medical Practice After Residency **https://www.foma.org/uploads/3/9/8/0/39809635/transitioning_into_practice_after_residency.pdf** Accessed August 25, 2021

Medscape Physician Compensation Report 2021: The Recovery Begins **https://www.medscape.com/slideshow/2021-compensation-overview-6013761** Accessed January 13, 2022

Headmirror.com Business of Medicine Course: an online podcast covering a wide range of useful non-clinical topics related to going into practice. Accessed September 14, 2021

AAO/HNSF Practice Management Education Committee
A Day in the Life of a Private Practitioner **https://www.entnet.org/resource/a-day-in-the-life-of-a-private-practitioner/** Accessed September 14, 2021

A Day in the Life of an Academic Otolaryngologist **https://www.entnet.org/resource/a-day-in-the-life-of-an-academic-otolaryngologist-practitioner/** Accessed September 14, 2021

How to Open a Private Medical Practice, Step by Step **https://www.businessnewsdaily.com/8910-opening-a-medical-practice.html** Accessed September 14, 2021

Who's Happier: Employed or Private Practice Physicians? **https://comphealth.com/resources/whos-happier-employed-or-private-practice-physicians/** Accessed September 14, 2021

Contract Negotiation Video Series **https://www.entnet.org/get-involved/sections/young-physicians-section/contract-negotiation/** Accessed September 14, 2021

OUT OF COMMITTEE: SLEEP DISORDERS

Oral Appliances for Obstructive Sleep Apnea, in Our Hands

Ofer Jacobowitz, MD, PhD
Sleep Disorders Committee
Chair-elect

Whether you call them oral appliances, mandibular advancement devices, or as some of my patients say, "the mouthpiece," they have become an established and valuable therapy for obstructive sleep apnea (OSA). There are numerous over-the-counter, boil-and-bite appliances and more than 100 custom appliances available.

Otolaryngologists can and do provide comprehensive therapy for OSA, using positive airway pressure (PAP), upper airway surgery, and oral appliance therapy (OAT). Oral appliances are not dental appliances treating the dentition but rather medical devices that are used to treat a medical disorder, namely OSA. When OAT is performed by an otolaryngologist who is contracted with commercial insurances, the therapy is typically much more affordable for the patient, as compared with the cost under dentists who may not accept the medical insurance plan's rate as payment in full.

OAT is an important option for many patients recognized by the American Academy of Otolaryngology–Head and Neck Surgery, which has a Position Statement advocating for OAT in the hands of otolaryngologist and qualified dentists. OAT can be a primary treatment option for patients with simple snoring or mild and moderate OSA. It is also a second-line option for severe OSA patients, intolerant of PAP (off label), or for subsequent treatment after upper airway surgery. It may also be a part-time option for patients who would like a portable option to use when traveling instead of PAP.

OSA is a heterogenous disorder and the severity of obstruction, degree of hypoxemia, and resultant effect on alertness and daytime function differ between patients. An important factor for successful treatment is the patient's preference, as regular adherence to treatment is critical for effectiveness of OAT and PAP. Oral appliances, which are more attractive to many patients as they are small, portable, silent, and intraoral and pose less of a stigma as compared with PAP, are usually preferred by patients over PAP and are thus twice as likely to be used compared to PAP.

The higher adherence to OAT may make it similarly effective as PAP for many patients. At the same time, careful patient selection for OAT is important since it is not effective in all patients, especially in those with very severe respiratory compromise or with extreme obesity.

- The patient should be under regular care by a primary dentist and have adequate dentition—6 to 10 healthy teeth per arch, especially molars.
- Periodontal disease should be under good control.
- The patient should have adequate dexterity to place the appliance and remove it.
- Nasal obstruction should be treated as it will undermine effectiveness by leading to mouth opening in sleep and instability of the pharynx.
- Patients with bruxism may be treated but the excessive parafunctional activity may reduce the lifespan of the appliance or result in breakage.
- Patients with current temporomandibular joint (TMJ) pain or jaw locking should be excluded, but past TMJ pain or joint sounds without pain are not a contraindication to treatment.

Predictive factors for successful outcomes are not sufficiently established, but simple endoscopy in the office can be of benefit. For mandibular advancement to be effective, there needs to be sufficient coupling between the mandible and the pharynx with dilation or stabilization of the narrow velopharynx on protrusion. Office fiberoptic endoscopy revealing a large change in the cross-sectional area with active mandibular advancement is indicative of good coupling and predicts a higher likelihood of successful treatment. Sleep endoscopy may also be potentially useful for selection where the

presence of tongue base collapse is a good prognostic feature, but severe lateral wall and circumferential complete collapse are negative prognostic features. Sleep study parameters can also be of value where positional OSA is associated with better success. Patients who previously tried PAP with pressure settings <8cm or <12cm, depending on the study, may have better outcomes.

Side effects can occur and include pain or occlusal changes. Pain may occur early in treatment and usually resolves, but some patients may discontinue OAT for this reason. Due to risk of occlusal changes, it is best to avoid OAT in patients who had recent orthodontic therapy or for whom bite changes would be a major concern. Those with a class 2 bite with overjet may be better candidates as bite changes may not necessarily be unfavorable in many. It is preferable to start with conservative mandibular advancement of ~3mm or edge-to-edge position and advance gradually with close follow-up and attention to any changes. Exercises performed in the morning after use may reduce side effects and occlusal changes. It is important to discuss and document the risk of occlusal changes in the informed consent process.

Most commercial insurances provide coverage for oral appliances, but it is advised to check the local carriers' policies and experience of others in one's region to make sure work and expense will be compensated. Some insurers require failure with a PAP trial of 45 days or longer prior to OAT approval. Unfortunately, the Centers for Medicare & Medicaid Services has excluded medical doctors from providing OAT, due to self-referral issues, and this results in limited access to treatment and higher cost to seniors. As far as coding, E0485 is used for thermoplastic appliance (boil-and-bite) fitted in the office. E0846 is used for custom appliances, for which impressions are taken and a dental lab manufactures the custom appliance specific for the patient. ■

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National Sleep Awareness Week Is March 13-19: Be a Sleep Health Advocate!

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- Snoring, Sleeping Disorders, and Sleep Apnea
- Continuous Positive Airway Pressure (CPAP)
- Treatment Options for Adults with Snoring
- Surgery for Obstructive Sleep Apnea
- Tips to Improve Your Sleep Quality
- FAQs: Rhinoplasty Patients with Obstructive Sleep Apnea (OSA)

ENThealth Sleep Journal

Tracking your sleep patterns and being aware of daily situations that help—or hinder—a good night's rest can help you establish and maintain healthy sleep habits. You can print copies of this document to keep by your bedside for easy, effective journaling before you go to bed each night and when you wake up each morning, or you can fill it out electronically to share with your healthcare provider.

Be ENT Smart: A good night's sleep helps you stay healthy and energized throughout the day!

Start Date: _____	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
What time did you go to bed?							
What exercise did you do today? When?							
Did you nap? When and for how long?							
What did you eat or drink before bed? When?							
Did you take any medications or supplements before bed?							
Did you have caffeine or alcohol today? When?							
How many times did you wake up during the night? Why?							
What time did you get up? Hours slept?							
How was the quality of your sleep? Great? Average? Poor?							
Observations							

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Icahn School of Medicine at Mount Sinai • Department of Otolaryngology – Head and Neck Surgery

The **Mount Sinai Health System Department of Otolaryngology – Head and Neck Surgery** is seeking applications for full-time Pediatric Otolaryngologists and General Otolaryngologists to join the academic staff at the Icahn School of Medicine at Mount Sinai. The Department of Otolaryngology is expanding its clinical practice throughout the 5 boroughs of New York City, Long Island and New Jersey.

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Program Manager
Mona.Kim@mountsinai.org

Mount Sinai

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Seeking Assistant Professor, Associate Professor, or Full Professor or Clinical Assistant Professor, Clinical Associate Professor, or Clinical Professor for the Division of Comprehensive Otolaryngology Stanford University School of Medicine
Department of Otolaryngology-Head and Neck Surgery

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The successful applicant should be board-eligible or board-certified in Otolaryngology-Head and Neck Surgery.

We expect the successful candidate to develop an active clinical practice in general otolaryngology, be an active teacher of medical students and residents, oversee the clinical program, and (for MCL) maintain an excellent clinical and/or translational research program.

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The Otolaryngology – Head and Neck Surgery Department, School of Medicine, and Stanford University value faculty who are committed to advancing diversity, equity, and inclusion. Candidates may optionally include as part of their research or teaching statement a brief discussion of how their work will further these ideals.

Submit CV, a brief letter and the names of three references to Lori Abrahamsohn, Faculty Affairs Administrator, Department of Otolaryngology-Head and Neck Surgery, at lori4@stanford.edu, 650.724.1745.

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Nadir Ahmad, MD, FACS
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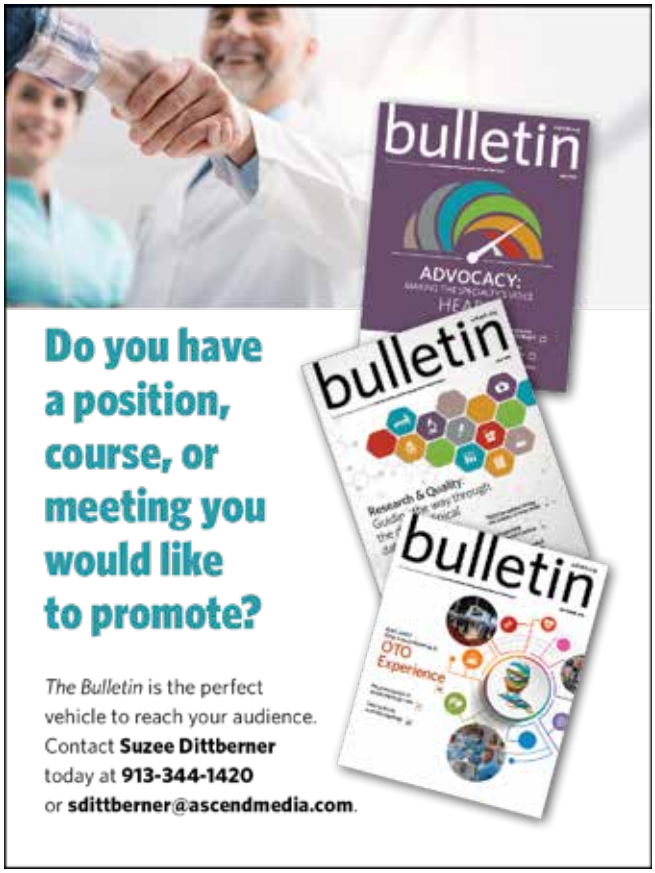

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Opportunities

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Interested candidates, please reach out to **Ken Altman, MD, PhD, Chair, Department of Otolaryngology – Head & Neck Surgery, and Professor – Geisinger Commonwealth School of Medicine, 100 N. Academy Avenue, Danville, PA 17822** at **kaltman@geisinger.edu** or apply online at **jobs.geisinger.org/physicians.**

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