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

SEPTEMBER 2022

WORLD SINUS HEALTH AWARENESS DAY
SEPTEMBER 28

NAVIGATING YOUR PATHWAY TO BETTER SINUS HEALTH

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26 Upper Aerodigestive Tract Manifestations of COVID-19: Voice, Airway, and Swallowing

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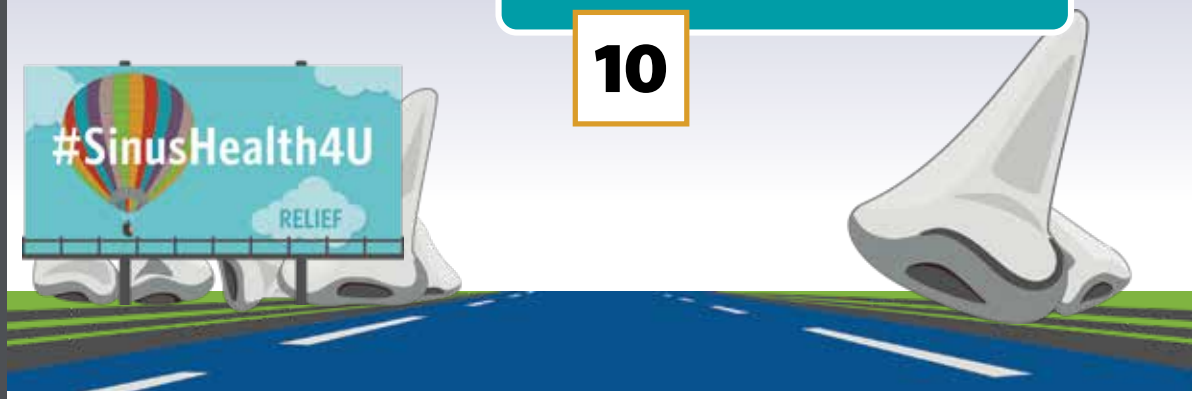

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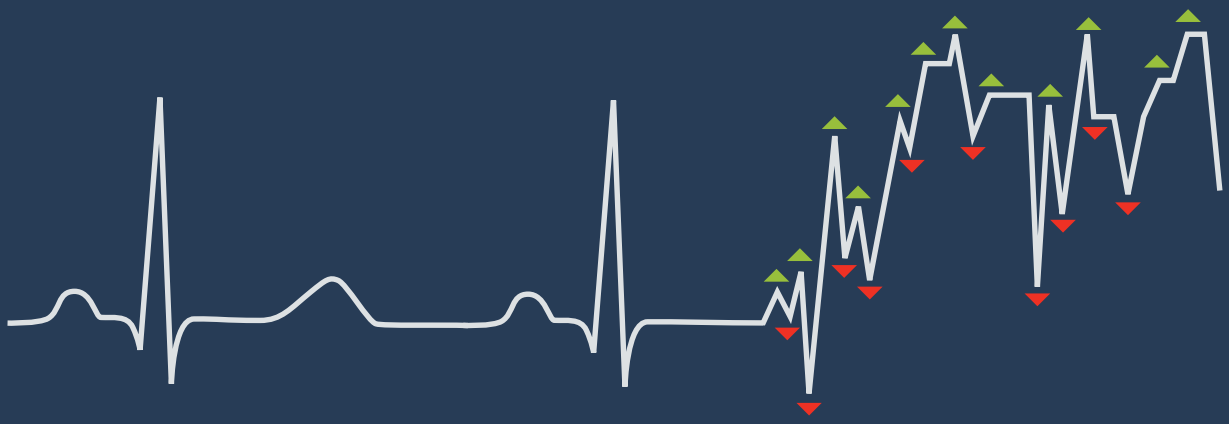
WHOSE INTERESTS

does your malpractice insurer have at heart?



Yet another medical liability insurer has transitioned from focusing on doctors to focusing on Wall Street. This leaves you with an important question to ask: Do you want an insurer that's driven by investors? Or do you want an insurer that's driven to serve you—one that's already paid $140 million in awards to its members when they retire from the practice of medicine?

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An Appreciative Farewell

Don't stop thinking about tomorrow,
Don't stop, it'll soon be here.
It'll be better than before. ~ Fleetwood Mac

Serving as President of the AAO-HNS/F has been the highest honor and privilege in my otolaryngological career. I recall my full awe as a resident at the vast activities and offerings that the Academy afforded, and I stand in equal awe as a senior attending as the Academy deftly moves nimbly, responsively, and respectfully to the ever-changing needs and demands of our membership.

Thank you to the hard work of numerous task forces and committees over the past year, including the Future of Meetings Task Force—appointed by Immediate Past President **Dr. Carol Bradford** and led by incoming President **Dr. Kathleen Yaremchuk**—that is studying the needs for future meetings and planning modifications. The Socioeconomic and Workforce Task Force, under the guidance of **Dr. Andrew Tompkins**, has been working to gain a current and accurate understanding of our members' demographics, training needs, and practice models and concerns. They have recently distributed a Workforce and Socioeconomic survey that I encourage everyone to complete.

The Private Practice Study Group (PPSG) has created a home for all private practitioners, particularly those who felt increasingly isolated from the Academy. A critical component of the Strategic Plan's Business of Medicine pillar, the PPSG has triggered an explosion of enthusiasm and energy and should soon attain section status. This group is working alongside 3P (Physician Payment Policy) Workgroup, our Advocacy team, ASCENT (Administrator Support Community for ENT), and the Board of Governors to tackle mounting provider concerns. Thanks to the Chair, **Dr. Marc Dubin**, and Vice Chair, **Dr. David Melon**, as well as to **Drs. Eugene Brown, Bill Blythe,** and **Mary Mitskavich** who were instrumental in initially forming this group.

Dr. James Denneny is a truly remarkable EVP/CEO whose vision, foresight, and wholehearted dedication to identifying, understanding, and problem solving the numerous issues that face our members is fierce and pointed. Thanks to Dr. Denneny, the AAO-HNS/F is highly regarded as an organization that successfully advocates for governmental and private payer regulation reform and that provides leadership and vision in the broader houses of surgery and medicine at home and internationally. Thank you, Jim, for your leadership and your unyielding commitment and support.

Please thank our amazing Academy staff. They are the engine that propels our organization forward and often goes beyond their call of duty as witnessed during our hybrid 2021 Annual Meeting in Los Angeles. Special kudos to Christina Maggio, Carrie Hanlon, Elise Swinehart, and Maura Farrell who have extended me incredible assistance during this past year.

I am fortunate to have the full support of my current practice partners while serving this past year—**Drs. Ron Hirokawa, Eaton Chen, Paul Fortgang, Maria Byrne, Michael Willett, Mark D'Agostino, Howard Boey, Tiffany Chen,** and **Jeff Cranford**. Thanks also to my former practice partner, **Dr. K.J. Lee**, who provides innovative and thought-provoking reflections. All our recent Academy presidents have provided me sage advice, particularly **Dr. Greg Randolph** and **Dr. Gavin Setzen**.

Medicine faces a plethora of challenges. Comprehending and tackling the ongoing parade of governmental and private payer regulatory obstacles will remain a top priority, with the -25 modifier issue currently in the spotlight. Physicians' emotional, physical, and mental health needs continue to escalate, especially during this peri-COVID-19 period, with a genuine need for solutions and strategies to equilibrate the burnout versus wellness cycle. Inclusive diversity and equity remain a key pillar of our Strategic Plan and our Diversity, Equity, and Inclusivity Committee continues to identify and address opportunities for improvements. Our international team, under the helm of Coordinator **Dr. Mark Zafereo** and Joint Meetings Liaison **Dr. Pablo Stolovitzky**, has done a remarkable job attracting new members and fostering international collaboration and friendships.

Our future is bright as **Dr. Kathleen Yaremchuk** assumes the Presidency, and **Dr. Douglas Backous** rises to President-elect. Thank you to the many committed physicians and providers who contribute their incredible talents, skills, and energy to the Academy.

On a final note, please do plan to join us at the 126th Annual Meeting of the AAO-HNSF in Philadelphia, Pennsylvania. Tremendous educational offerings have been planned, vendors at the OTO Experience are eager to share new technologies and products, and social gatherings including the Presidents' Reception at The Filmore on Saturday, September 10, 2022, will be magical and memorable.

I am deeply humbled and touched to have served as President and will forever cherish and use my new bonds, friendships, and insights to continue to advance our great organization. ■

Ken Yanagisawa, MD
AAO-HNS/F President

“I am deeply humbled and touched to have served as President and will forever cherish and use my new bonds, friendships, and insights to continue to advance our great organization.”

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The Annual Meeting: Offering a Different Type of Time-Out

Planning for and executing this year's Annual Meeting & OTO Experience in Philadelphia, Pennsylvania, has been influenced by our 2020 virtual meeting, last year's 125th anniversary in-person meeting in Los Angeles, and the recently held Pan American Congress in Orlando. Travel schedules have become more flexible, and with vaccination mitigating the severity of COVID-19 infections for the majority of the population, the willingness and ability to attend in-person meetings has resulted in record-breaking submissions for this year's scientific program. The Annual Meeting Program Committee has included concepts brought forward by the Future of Meetings Task Force and our consultants, 360 Media, to create and fine-tune novel programming that will be well received by registrants for this year's meeting.

An emerging theme throughout the planning process of this meeting has been the intense desire of our attendees to engage in face-to-face committee meetings, assemblies, and receptions and to have fun at a variety of social events available at the meeting. This year a number of successful scientific meetings have been conducted that reinforced the value of collegiality and community within our specialty and the value of personal interactions that have become the highlights of these large gatherings.

The timing of this meeting coincides with some easing of COVID-19 concerns, but 2022 has been a volatile year on many fronts relating to the practice of otolaryngology and additionally economic, political, and social issues that, when taken in toto, have stressed our members to and beyond reasonable limits. I hope this meeting will allow attendees to experience a safe space to relax, relate, and recharge through interactions with existing friends and colleagues and new acquaintances that will be made at the meeting.

I hope you will take the time to listen and share experiences and emotions honestly and empathetically. The value of sharing one's situation and things that are particularly troublesome unquestionably benefits both the listener and speaker, even when no resolution is found. Even though this meeting is jam-packed with education content and social opportunities, I would encourage you to take some time for yourself and not do everything listed on the schedule. Consider this your personal "time-out" in which you engage in the things you like most about the profession and specialty, whether it be learning new things, renewing past friendships, teaching others, or just having a good time, try to focus on the rewarding aspects of your life and come out of the storm. I think you'll find many of your friends and colleagues will join you in the shelter that this meeting can be.

The meeting in Philadelphia will mark the final Annual Meeting in the tenure of **John H. Krouse, MD, PhD, MBA**, as Editor-in-Chief of our journals, *Otolaryngology–Head and Surgery* and *OTO Open*. Dr. Krouse has served two terms as editor with distinction and innovation that have resulted in the highest Impact Factor in our journal's history each of the last two years. Under his leadership, the journal initiated a program to train residents in quality peer review and the Resident Reviewer Development Program has been training new cohorts for five years. *OTO Open*, our open access publication, was launched in 2017. He created focused issues that highlighted health equity and diversity and showcased articles from first authors 40 years of age and under (40 under 40), as well as produced monthly podcasts to promote the research published in the journals. Dr. Krouse has positioned our journal well as we begin a new era with Wiley as our publisher in January 2023. His dedication to excellence and willingness to embrace meaningful change has allowed our journal to soar, and he deserves the heartfelt gratitude for his contribution to our specialty.

I would especially like to recognize and thank **Ken Yanagisawa, MD**, for his leadership and support as this year's President. He has committed significant amounts of his time to identify critical areas of our Strategic Plan and help drive and support key Academy initiatives related to them. His unwavering support of key advocacy efforts related to the practice of otolaryngology and medicine in general, as well as the needs of the private practice community, has been crucial. His attention to the otolaryngology workforce through the task force he created will pay dividends for many years to come as we more completely understand the resources we have to work with in restructuring the healthcare delivery system.

I hope all of our attendees from around the world will enjoy this meeting and recognize that you too can make a difference if you so choose. ■

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

“This year a number of successful scientific meetings have been conducted that reinforced the value of collegiality and community within our specialty and the value of personal interactions that have become the highlights of these large gatherings.”

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AAO-HNSF Humanitarian Travel Grant Report: Project Ear

Michael M. Li, MD, and **Akash N. Naik, MD**, traveled to the Los Alcarrizos in the Dominican Republic to participate in the biannual Project Ear trip, led by **Edward E. Dodson, MD.** For over 25 years, Dr. Dodson has been helping the underserved population of Los Alcarrizos, while simultaneously building the foundation for otologic surgery at the nearby Hospital Dr. Salvador B. Gautier in Santo Domingo. Through the years, Dr. Dodson has not only donated microscopes, drills, and supplies to the residency program at the Gautier hospital, he has also educated generations of Dominican residents.

During their weeklong stay, they had the opportunity to operate at both the mission hospital in Los Alcarrizos and the Gautier teaching hospital. In Los Alcarrizos, they each performed several surgeries for cholesteatoma and tympanic membrane perforation. In total, their group, which also included **Laura A. Matrka, MD**, a laryngologist from The Ohio State University Wexner Medical Center, performed more than 30 surgeries during the course of the week, including high-complexity airway reconstructions. Otolaryngology residents from the Gautier hospital, one of only two otolaryngology residency programs in the country, came each day to operate and learn from Dr. Dodson.

"An aspect of Project Ear that was especially rewarding was working with colleagues from anesthesia, nursing, and administration who also joined the trip. Working in such close proximity helped break down the usual barriers that exist in the hospital setting and created a more congenial environment back home. Project Ear was one of the most rewarding things each of us has participated in since starting residency. We both hope to return as attendings and continue the incredible work Dr. Dodson has carried on for over 25 years," Dr. Li and Dr. Naik shared. ■

OTO Journal

OTO OPEN

Don't Miss the Latest Podcast from OTO Journal

To access the full library of podcasts hosted by **John H. Krouse, MD, PhD, MBA**, Editor in Chief of *Otolaryngology–Head and Neck Surgery* and *OTO Open,* visit **https://sageotolaryngology.libsyn.com**.

Some recent topics include:
Sinus Radiological Findings in General Asymptomatic Populations: A Systematic Review of Incidental Mucosal Changes, with the senior author of the paper, **Richard J. Harvey, MD, PhD,** and Associate Editor, **Jivianne T. Lee, MD**

Health Equity and Diversity in Otolaryngology, with **Earl H. Harley, MD, Howard W. Francis, MD, MBA,** and **Ciersten Burks, MD**

Association of Pediatric Hearing Loss and Head Injury in a Population-Based Study, with senior author of the paper, **Elliott D. Kozin, MD,** and **Associate Editor Thomas Q. Gallagher, DO**

Objective Improvement After Frenotomy for Posterior Tongue-Tie: A Prospective Randomized Trial, with lead author, **Bobak A. Ghaheri, MD,** and Associate Editor, **Thomas Q. Gallagher, DO**

Predictive Pediatric Characteristics for Revision Tonsillectomy After Intracapsular Tonsillectomy, with the senior author of the paper, **Richard J. Schmidt, MD,** and Associate Editor, **Sarah N. Bowe, MD**

Cochlear Implantation Hearing Outcome in Ménière's Disease, with **Steven D. Rauch, MD**, senior author of the paper ■

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INTERVIEWEE
Patrick K. HA, MD
Chief of the University of California San Francisco Division of Head and Neck Surgical Oncology, and Irwin Mark Jacobs and Joan Klein Jacobs Distinguished Professor in Head and Neck Cancer

INTERVIEWER
Vikas Mehta, MD, MPH
Associate Professor, Department of Otorhinolaryngology - Head & Neck Surgery, Albert Einstein College of Medicine

pearls from your **peers:**

Molecular Diagnostics and Targeted Therapeutics for Salivary Gland Neoplasms

What molecular testing is necessary right now when deciding management for certain salivary gland malignancies?

For many salivary gland malignancies, histology alone may not be sufficient for accurate diagnosis and categorization. The use of additional protein, hormonal, and fusion markers is commonplace and necessary to help the pathologists. Send-out tests looking for molecular fusions, such as ETV6-NTRK3 for secretory carcinoma, Myb-NFIB for adenoid cystic carcinoma, or CRTC1-MAML2 for mucoepidermoid carcinoma, can solidify the histologic findings, particularly for dedifferentiated tumors or if there is histologic overlap.

What does the future hold for molecular diagnostic tests for salivary gland neoplasms?

It is likely that a panel of markers will be assembled to help with the diagnosis of salivary gland tumors. This is perhaps more needed in the realm of fine needle aspiration biopsy classification, wherein the cytology can be meaningful but not absolute. A molecular panel that would incorporate many of the known markers as well as unique gene rearrangements would be helpful.

What does the current clinical trial landscape suggest for the role of targeted therapies based on molecular profiling of salivary gland malignancies?

Although the success of targeted therapies for salivary gland cancers has been limited in the past, there is increasing hope that we can capitalize on some of the unique features of salivary gland cancers. For example, the use of hormonal treatments for salivary duct carcinoma, which often express androgen, estrogen, or progesterone receptor, has shown some benefit and is being studied. The development of Trk inhibitors is also specific for recurrent or metastatic secretory carcinomas that universally express Trk-fusion proteins.

There are many other unique molecular alterations in salivary gland cancers, such as unique gene fusions that might be important in driving these cancers. However, we have a poor understanding of what these gene rearrangements are doing and how to disrupt them; therefore, there is much work to be done before we can understand how to capitalize on these unique alterations. ■

WORLD SINUS HEALTH AWARENESS DAY
SEPTEMBER 28

NAVIGATING YOUR PATHWAY TO BETTER SINUS HEALTH

To access all the resources developed for World Sinus Health Awareness Day 2022, go to **www.entnet.org/WSHAD**.

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Medtronic

Participate in World Sinus Health Awareness Day

Help Patients Navigate Their Pathway to Better Sinus Health

World Sinus Health Awareness Day (September 28) is designed to inform and educate patients around the world about the causes of their nasal and sinus symptoms as well as various treatment options and when they should seek additional specialized care. The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS), in collaboration with the American Rhinologic Society and corporate partner Medtronic, is providing accessible public and patient information that will assist individuals in understanding their own individual journey to better sinus health.

Bringing attention to the impact of chronic symptoms of nasal obstruction and congestion, nasal drainage, facial pressure, and/or decreased smell that are not responding to medications or other treatments is a focus point of World Sinus Health Awareness Day. Arming patients and their caregivers with clinically proven information is an essential part of this campaign so that they can navigate their way to better sinus health.

How to Participate

There are several ways for you and your practice to participate in World Sinus Health Awareness Day. A toolkit of resources has been developed and is available to you and your practice to help share this crucial information. The materials available to you in the World Sinus Health Awareness Day Toolkit include:

- Webinar geared toward the patient audience featuring a panel of expert otolaryngologists answering patient questions about sinus and nasal symptoms, treatments, seeking medical care, and more.
- Printable World Sinus Health Awareness Day poster
- World Sinus Health Awareness Day one-pager
- List of ways to participate
- Patient information handouts
- Sample social media posts and graphics, including animated graphics
- Sample patient letter/email
- And more! ■

WSHAD Webinar 2022

Navigating Your Pathway to Better Sinus Health Webinar: Expert Panelists Answer Patients' Questions *#SinusHealth4U*

When: Sunday, Sept 11, 2:15 - 3:15 pm (ET)

>> **3:30 – 4:00 pm: Erich P. Voigt, MD**, host of the Sirius XM Doctors' Radio ENT Show, welcomes the panelists to the live broadcast of the show from the floor of the OTO Experience. Tune in to Channel 110 to listen live.*

Who:

Moderator: **James C. Denneny III, MD**

Participants:

- **Pete S. Batra, MD**
- **Gene G. Brown III, MD**
- **Dana L. Crosby, MD, MPH**
- **Stacy T. Gray, MD**
- **Erich P. Voigt, MD***

Where:

Livestreamed from the AAO-HNSF Annual Meeting & OTO Experience – a recording will be made available after the Annual Meeting and will be posted on www.entnet.org/WSHAD and www.ENThealth.org/SinusDay.

"Understanding the options for nasal and sinus symptom treatments can be overwhelming, so we initiated this public service campaign in 2021 as a way to reach patients around the world with reliable information that not only helps them more fully and better understand their symptoms, but also helps them decide when it is time to see a physician."

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

"Otolaryngologists are well-positioned to treat nasal and sinus issues both medically and surgically if necessary, and the American Rhinologic Society is proud to partner with the American Academy of Otolaryngology–Head and Neck Surgery on this important initiative, which will help educate patients so they can access the best care."

—Michael G. Stewart, MD, ARS Executive Vice President

"Medtronic is committed to helping ENT patients all over the world, and proper education is one of the most important steps...We appreciate AAO-HNS and ARS partnering to launch this campaign last year, and we are proud to be a key partner once again in sharing this critical awareness information with those who suffer from sinus issues and their caregivers."

—Amy Van Sach, Medtronic ENT Vice President of Strategy and Acting General Manager of the Intersect ENT business

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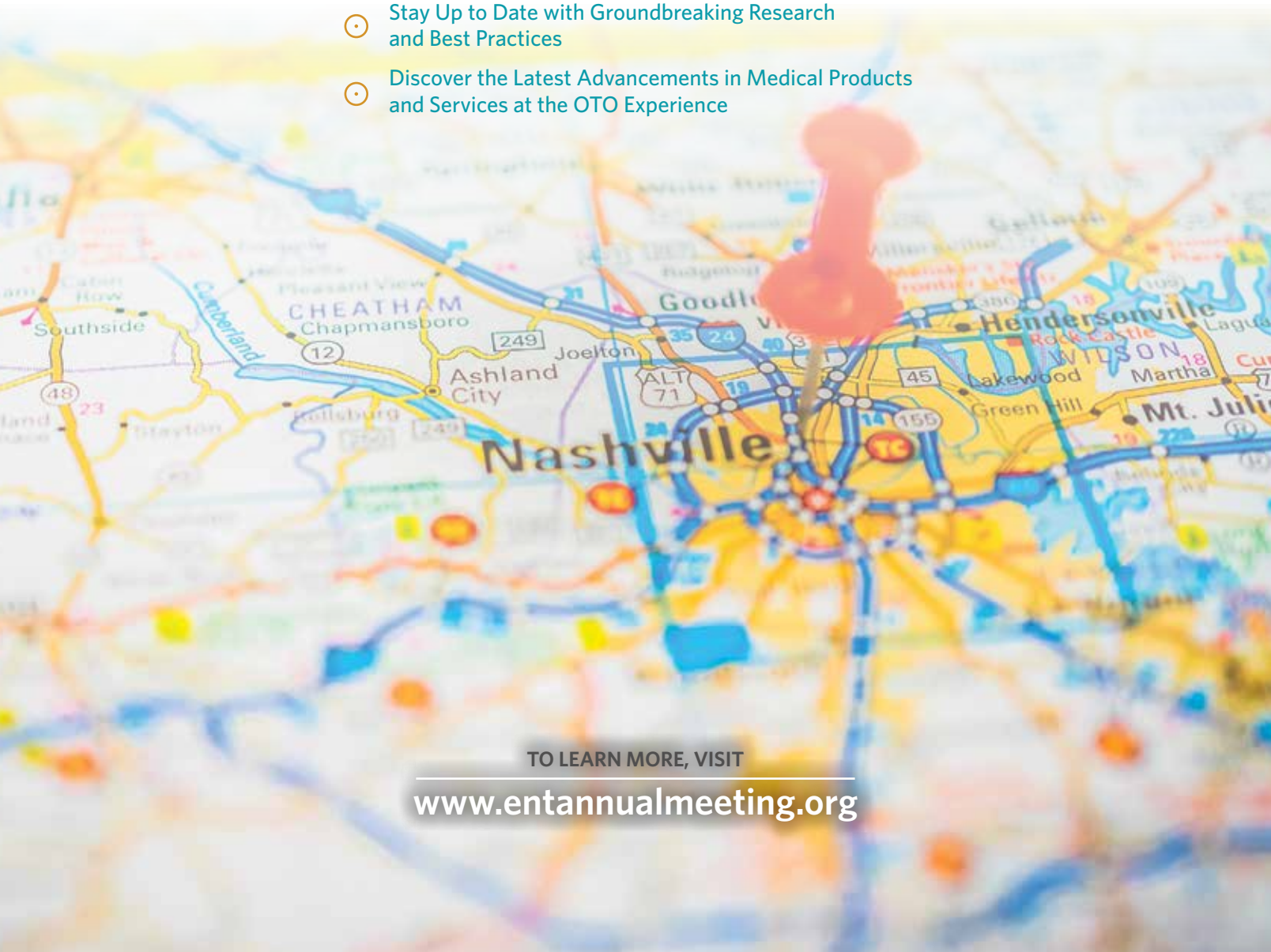

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Foundation Education:

Jeffrey P. Simons, MD, MMM
AAO-HNSF Coordinator for Education

Core to the mission of the American Academy of Otolaryngology–Head and Neck Surgery and its Foundation (AAO-HNS/F) is education. The COVID-19 pandemic's impact on medical education and professional training has been profound.

As education leaders at the Foundation, we are committed to ensuring that we are adapting and evolving to meet the growing education demands of healthcare providers.

OTO Logic is the #1 Online Source for Otolaryngology Education

OTO Logic, the AAO-HNSF online otolaryngology education source, continues to reflect that adaptation. In the past year, our data analytics revealed that the number of returning learners has doubled from the previous year. As the AAO-HNSF 2021 Annual Meeting & OTO Experience pivoted to a hybrid event, the number of CME/MOC courses reached a new record, increasing from 400 CME/MOC courses in 2020 to 824 in 2021. This growth would not have been possible without the impressive number of faculty who offered their time, expertise, and flexibility to deliver presentations and courses, both in person and on demand.

Brian Nussenbaum, MD, MHCM, Executive Director, American Board of Otolaryngology – Head and Neck Surgery (ABOHNS), addressed Foundation education leaders at the Spring Education Steering Committee meeting held in May 2022. The ABOHNS provided insightful feedback and continuing certification data analytics. As part of that presentation, the AAO-HNSF learned that we are **ranked the No. 1 top provider of CME/MOC otolaryngology education** (2021 and 2020) as reported to the Accreditation Council for Continuing Medical Education (ACCME). Ranked second was the American Academy of Sleep Medicine, and third was the American Medical Association.

The Proof Is in the Pudding

It is one thing for me to tell you these numbers, but it is more important for me to demonstrate to you the value of what the AAO-HNSF education has to offer. We invite you to check out the free CME activities offered, selected from the variety of learning formats available in www.OTOLogic.org. When you log in, search under the tag titled "Free CME."

Building Education for the Profession

Here are some of our accomplishments this year. I want to emphasize how the Education Steering Committee, members of the nine Education Committees with nearly 300 volunteer members, and Education staff, led by **Tirza Lofgreen, CHCP**, Senior Director, Professional Education & Digital Learning, have worked on your behalf to advance otolaryngology education.

- Launched eight new sections of FLEX, each offering nine different creative and contemporary learning modalities.
- Led sessions at the Annual Meeting focused on cases and controversies on obstructive sleep apnea and neoplasms, as well as lunchtime table-topics discussions based on this year's FLEX topics.
- Expanded offerings to nearly 20 simulation education sessions and hands-on surgical skills training via a collaboration of the Simulation Education Committee and the Annual Meeting Program Committee.
- Developed 15 new online digital courses.
- Released 400+ new case-based questions with rationales in OTO Quest – Knowledge Assessment Tool.
- Continued collaborative initiatives with ABOHNS to support CERTLink™ with 4,569 diplomates who successfully completed the program in 2021.
- Provided clinical and practice management articles in each edition of the *Bulletin* ("From the Education Committees" and "Pearls from Your Peers").
- Offered 1,637 activities in OTO Logic and welcomed 7,821 new learners.

New Offerings

Otolaryngology Patient Scenarios

This past year, Foundation education volunteers and original authors completed

Year in Review

the Otolaryngology Patient Scenarios (OPS) library—formerly the ABOHNS Self-Assessment Modules (SAMS). There are more than 60 patient-based scenarios to assess knowledge and gain mastery. Each course offers 1.0 CME/MOC credit.

OTO Media Gallery

Members now have free access to a searchable gallery of otolaryngology images and surgical video procedures. This visually elegant platform has been launched to share, store, track, and manipulate our growing assets. We gratefully acknowledge the image donations from **Eiji Yanagisawa, MD**, and AAO-HNS/F Past President **Eugene N. Myers, MD, FRCS Edin (Hon).** The platform includes a dynamic search function with the ability to search by subspecialty, topic, diagnosis, and other keywords as well as the option to download to use in courses, presentations, and more!

Serious Games

If you didn't get an opportunity to take the first course on *Complex Airway Management Simulation*, be sure to visit OTO Logic. The course assists learners to identify the critical steps to obtain and secure a difficult airway on a patient who has a large supraglottic mass that is bleeding. We will be releasing our second serious game on the topic of injectable fillers next year. The Facial Plastics & Reconstructive Surgery Education Committee will be collaborating with the Simulation Education Committee to build this new course.

I would like to especially acknowledge and extend my gratitude to the following Education Steering Committee leaders for their dedication and service during their term as Chair of their respective committees. ■

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

Lance A. Manning, MD
Chair, Practice Management Education Committee

Kelly Michele Malloy, MD
Chair, Simulation Education Committee

Secure FLEX Early-Bird Pricing by September 14
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Non-Procedural Management of COVID Patients: COVID's Sinonasal Sequela and How to Provide Help for Patients in Need

Christie A. Barnes, MD, committee member

If you're like me, you would really like to stop talking about COVID. You would prefer to move from the shadows of this disease and toward "normalcy." But the reality is that many of our patients are still suffering, and we are not yet out of the woods. Throughout the course of this pandemic, we have gone from fear of the unknown to a deeper understanding of the disease, though many questions about the long-term sequela of this infectious disease loom large. Hundreds of millions have suffered the effects of this virus, and a large percentage of these patients will have suffered sequela of smell loss and headaches and will be seeking guidance and care. In this article, I review the most recent information on these common complaints, discuss current diagnostic and treatment strategies, and share the experience of otolaryngology colleagues nationwide in the care of this cohort of patients.

What Is the Experience of Colleagues Nationwide?

I wanted to understand if my experience with neurological sequela in post-COVID patients was typical of what otolaryngologists and rhinologists around the country were seeing. I contacted colleagues all over the United States. Unsurprisingly, the most common complaint following COVID infection seen in ENT clinics is smell and taste disturbance. The providers I spoke to reported smell and taste disturbances to be 20%-70% more common than pre-COVID levels. Several reported that hyposmia or anosmia have become the minority of smell consult patients in the last year—unsurprising since media coverage has drawn attention to this symptom and because of its self-limiting nature. However, they have been seeing increases in parosmia/phantosmia complaints. Additionally, our colleagues nationwide report an increase in the number of "sinus headache" and "sinusitis symptoms" that appear to be temporally linked to a COVID infection. Often, these headaches are accompanied by a feeling of depressed functioning or cloudy feeling (brain fog), and there appears to be no consistent location for this type of headache. So, what do we know about the chronic neurologic sequelae after COVID?

Long COVID Syndrome Neurologic Sequela

Neurological complaints are not uncommon in post-COVID syndrome and often include dysgeusia, hyposmia, and headaches.[1] Headache in a recent meta-analysis is found in 8%-15% of patient in the first six months after infection.[2] Neurocognitive symptoms of brain fog include complaints of difficulty processing, short-term memory issues, and challenges with focusing.

A recent review describes the possible pathophysiology as one linked to the high affinity of SARS-CoV-2 for human angiotensin-converting enzyme (ACE2) receptor.[1] Noted is that "this receptor is also expressed in neurons and glial cells, which could explain the reported neurological manifestations, such as olfactory neuropathy (anosmia), peripheral neuropathy and brain disorders."[3] Furthermore, postmortem studies have revealed the presence of SARS-CoV-2 viral particles in the olfactory bulb, cerebral spinal fluid, and higher cortical centers.[3] It is also thought that the viral infection potentially leads to central cytokine storm, resulting in the symptoms of headache and potentially brain fog, though further investigation is needed to fully understand this and the potential overlap with neuropsychological symptoms.[2]

Several mechanisms have been proposed for olfactory disturbances, and currently it is felt that these mechanisms may overlap. These mechanisms include conductive obstruction due to edema in the olfactory cleft, direct injury to the olfactory epithelium, and potentially retrograde axonal transport to the olfactory bulb and higher cortical centers along the olfaction pathway.[4] Surveys of patients with hyposmia reveal that the majority of patients regain their sense of smell in the first four weeks of infection and more still in the first year. There is a small percentage of patients who in the first years of the pandemic have not recovered olfactory function. Post-COVID olfactory perception distortions (parosmias and phantosmias) have not been vigorously studied or reported.

Recommendations for Olfactory Dysfunction (OD)

For patients complaining of OD following COVID-19 infection, a thorough history is paramount. A recent *Bulletin* article by **Zara M. Patel, MD**, provides an excellent review of OD: "How to Diagnose and Manage the Patient with Olfactory Loss" **(https://bulletin.entnet.org/home/article/22197344/from-the-education-committees-how-to-diagnose-and-manage-the-patient-with-olfactory-loss)**.

Your physical exam should include nasal endoscopy. Imaging for post-COVID OD is not generally indicated unless finding on endoscopy or history suggests any other underlying condition, such as sinus disease (CT scan) or neurologic disease or malignancy (MRI). Validated olfactory testing is helpful in these patients. The disposable, validated, and quantifiable characteristics of the University of Pennsylvania Smell Identification Test (UPSIT) make it very useful in the clinical setting.

Treatments other than olfactory training do not have robust data to support them.[4] Oral and topical steroids in isolated post-COVID

OD have not been found to be as helpful as we would have hoped, unless the patient has concomitant sinus disease.[5]

Many of these patients with OD will come to you for advice, and any discussion on OD should include counseling on safety, quality of life issues, and prognostic factors. Reassurance that the majority of these patients will regain their smell and taste within the first year after infection is often helpful for patients who are distressed by this symptom. Counseling on fire and gas or propane leak detectors, the dangers of spoiled foods, and the social impacts of personal hygiene as their smell recovers provides valuable information to patients. Additionally, for those who suffer concomitant taste disturbances, counseling should include a discussion on judicious use of salt and sugar and instead substitution with spices, such as peppers and hot sauces. Patients with diminished taste may find varying textures of food can improve the enjoyment of mealtime.

Considerations for Parosmia and Phantosmia Patients

Patient with parosmia describe odorants smelling different than they remember or like something else entirely (i.e., peach smells like pond scum). Phantosmia patients will report an odor(s) that pervades their environment and often bleeds into the taste of their food in the absence of an odorant (i.e., everything smells of dirty gym clothes). Often, it is the unpleasant tastes and smells that bring patients in for an evaluation. Phantosmia patients, in particular, often go to great lengths to investigate the source of the smell and will report tearing up carpet, calling plumbers to investigate, and scrubbing their whole house with cleaner. The natural evolution of post-COVID olfactory perceptual distortions is unknown and needs to be further evaluated. These perceptual distortions are often distressing and can have a negative impact on the patient's quality of life. Olfactory testing and potentially imaging are often indicated in these patients, however ruling out another underlying cause is crucial. Assessment of these patients by a rhinologist may be warranted to ascertain if the distortion is central or peripheral and unilateral or bilateral. Referral to psychology should be considered as well for further evaluation if indicated.[4] Further studies need to be done to further understand these distortions in this setting.

Post-COVID Headache and Brain Fog

As with OD, history and physical exam are crucial. It is imperative to rule out sinonasal disease in patients with headache. Characteristics of the headache may point to etiology, and in the setting of a normal physical exam and normal endoscopic exam, may be the only clue to underlying disease. Careful consideration for other disease, such as primary headache disorder, tumor, secondary headaches such as sleep apnea related, and TMJ arthralgia, can be teased from the history.

Consultation with neurology is crucial for these patients as they can further assist with diagnosis and treatment. Many of my neurology colleagues relate that brain fog remains an issue for which there is little data. It has been postulated that the mechanism of this symptom is a chronic low-grade inflammatory state. My colleagues note that steroids, CoQ10, and other therapies, however, have been tried without any improvement of symptoms. From a practical clinical standpoint and from discussions with our neuropsychology colleagues, Elizabeth Hartman, MD, relates that post-COVID patients have several factors that contribute to brain fog, and she tries to focus on the treatable ones. Her conversations with patients focus on prioritizing restful sleep and treating insomnia or other sleep disorders, such as sleep apnea. She and her colleagues look for other contributors (thyroid, metabolic issues, such as B vitamin deficiencies, medication side effects, potential autonomic dysfunction, such as POTS, and rarely ruling out stroke/other more serious COVID-19 complications). She emphasizes helping patients start a graduated exercise program to improve exercise tolerance often with help of a physical therapist for a post-COVID program. Dr. Hartman also notes the importance of optimizing behavioral health, such as underlying or new depression and anxiety that have been exacerbated by not only illness but isolation, pandemic stressors, financial stressors, etc. Most importantly, she recommends trying to help the patient avoid or break out of a cycle of not feeling well and therefore becoming more inactive, getting more isolated, and then feeling worse.

Tailored treatments and rehabilitation are important for the recovery of patients with neurological sequela of COVID-19 infection. Often, these complex patients require the assistance of a multidisciplinary team of specialists. The otolaryngologist is often on the front lines encountering patients with these complaints. Treatments and understanding of the disease process are evolving, and we still have much to learn. ■

Special thanks to Elizabeth Hartman, MD, Associate Professor, Neurology Clinic Director, and Division Chief of Headache Neurology, Department of Neurological Sciences at the University of Nebraska Medical Center and many of my colleagues from the Department of Neurological Services who answered my many questions and provided expertise for this article.

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How Advanced Practice Providers Are Shaping Otolaryngology-Head and Neck Surgery

Elisabeth H. Ference, MD, Victoria S. Lee, MD, and **Michael J. Brenner, MD, Chair**

Advanced practice providers (APPs), which include physician assistants (PAs) and nurse practitioners (NPs), not only have a growing presence within our specialty, but are expanding the overall footprint of otolaryngology-head neck surgery in healthcare. From 2012 to 2017, there was a 51% increase in the number of otolaryngology APPs compared with a 2.2% increase in the number of physician providers.[1] There is an expected shortage of 1,620 otolaryngology physicians by 2025 per projections from the U.S. Department of Health and Human Services.[2]

Trends

Several factors have fueled the growth in APPs in otolaryngology, which increasingly help to meet the demand for ENT specialty care. Medical systems are seeking ways to stretch the existing physician workforce amid a fixed number of graduating residents. APPs can help meet patient needs amid pressures to expand access while managing expenditures. These needs are particularly acute in rural settings. Moreover, resident work hour restrictions have led to an increased need for help managing inpatients and postoperative patients in academic centers.[3] Last, in the community, increasing practice consolidation and the decline of the single-provider practice has led to larger groups with the ability to use and afford APPs.[4]

The geographic distribution of otolaryngology APPs differs from that of physicians and surgeons (Figure 1). A majority of rural counties (72%) in 2017 reported zero otolaryngology providers, and a greater proportion of rural counties (5%) were served exclusively by APPs as compared with urban counties (3%).[5] Otolaryngology APPs are more likely to practice in rural settings (14%) versus otolaryngology physicians (8%).[6] Within otolaryngology, however, states with laws allowing independent practice for NPs did not have a higher proportion of rural NPs, suggesting that state statutes might have only limited influence on APP practice distribution.[5]

The percentage of female APPs significantly exceeds that of female physicians in otolaryngology (Table 1).[1,6] Furthermore, there were no statistically significant trends or changes in the proportion of women APPs or women physicians billing Medicare between 2012 and 2017. In contrast, the increase in female otolaryngologists mirrors the increase of female physicians among all licensed physicians, suggesting that this disparity is a historical remnant likely to change as more women complete training.[1]

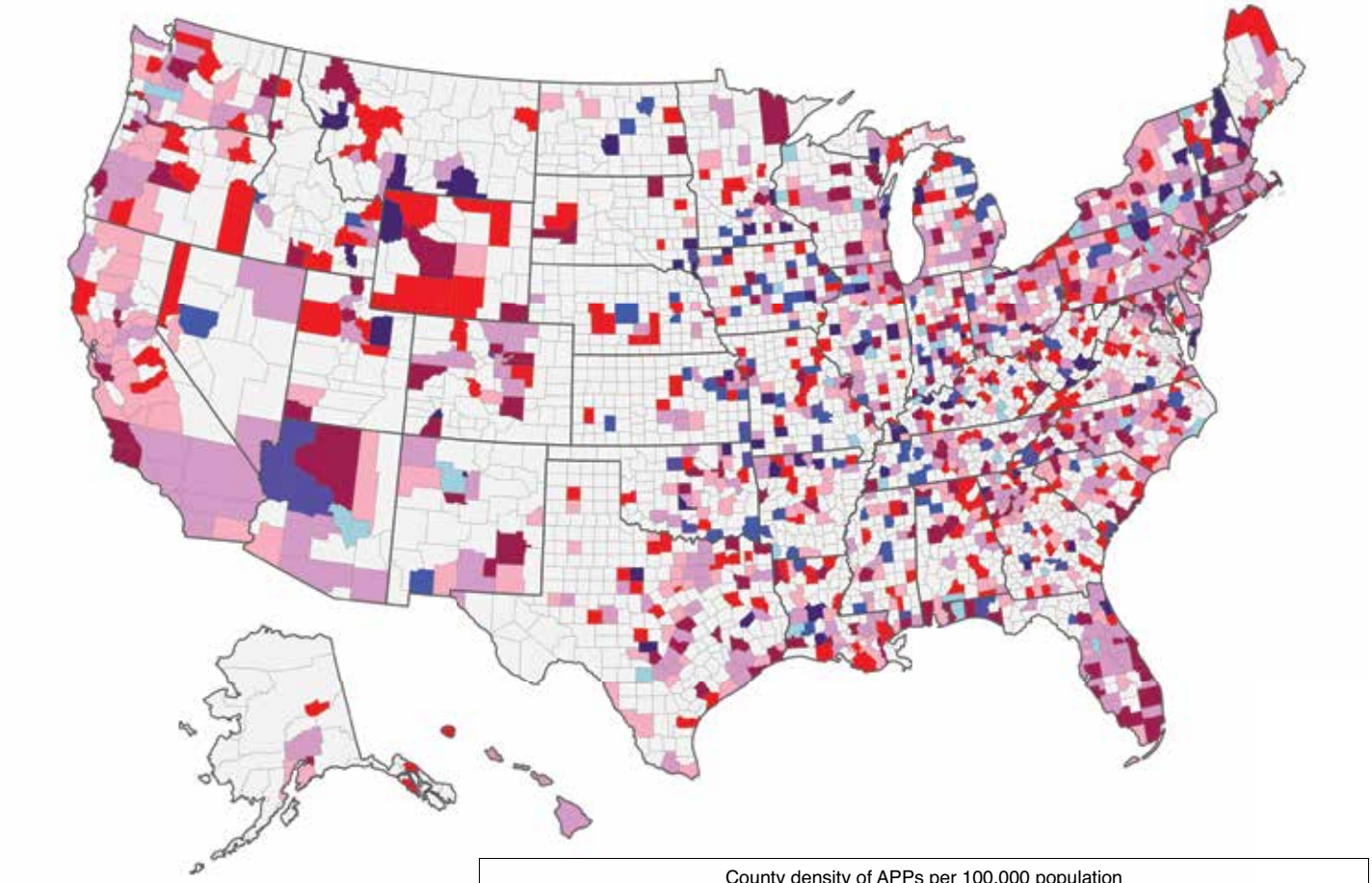
As the number of APPs providing otolaryngology has grown, scope of practice has been stable, focused on common clinic procedures. Between 2012 and 2017, the median number of Common Procedural Terminology (CPT) codes used, number of Medicare reimbursements, number of services, and number of patients per APP showed little change.[6] There has, however, been linear growth in total Medicare reimbursements, services, and patient visits by otolaryngology APPs proportionate to growth in the total number of otolaryngologic APPs.[6] The most common CPT codes APPs use are 31575 (diagnostic laryngoscopy), 69210 (cerumen removal), 92504 (binocular microscopy), and 31231 (nasal endoscopy). APPs are also performing tympanometry, audiometry, cautery, nasopharyngoscopy, and allergy skin tests at high volumes. The volume of APP services grew faster than physician providers services for all common clinic-based procedures except for balloon sinus dilation and tympanostomy tube placement.[5] The number of APPs who performed moderate complexity visits (99202-99204 and 99212-99214) nearly doubled between 2012 and 2017, but few APPs coded for 99215 and 99205, which are reserved for complex patients with high-risk problems.[1]

Few data are available regarding how the pandemic has shaped APP practice in otolaryngology, but anecdotally, many otolaryngologists have observed more patients

Table 1. Female representation by degree and year

	2012	2017	*P* value
Physician Female (% physicians)	1,015 (12.0)	1,329 (15.4)	0.198
APP Female (% APPs)	1,145 (78.1)	1,771 (79.7)	0.198

Note: Significance testing by multiple regression interaction term.



		County density of APPs per 100,000 population		
		0	>0 to 3	>3
County density of otolaryngologists per 100,000 population	0	APPs: 0 Rural Counties: 1426 (72.2%) Urban Counties: 344 (29.5%)	APPs: 52 (2.6%) Rural Counties: 24 (1.2%) Urban Counties: 20 (1.7%)	APPs: 109 (5.3%) Rural Counties: 75 (3.8%) Urban Counties: 17 (1.5%)
	>0 to 3	APPs: 0 Rural Counties: 114 (5.8%) Urban Counties: 174 (14.9%)	APPs: 862 (42.2%) Rural Counties: 78 (3.9%) Urban Counties: 282 (24.2%)	APPs: 94 (4.6%) Rural Counties: 17 (0.9%) Urban Counties: 12 (1.0%)
	>3	APPs: 0 Rural Counties: 170 (8.6%) Urban Counties: 114 (9.8%)	APPs: 744 (36.4 %) Rural Counties: 28 (1.4%) Urban Counties: 175 (15.0%)	APPs: 182 (8.9%) Rural Counties: 44 (2.2%) Urban Counties: 28 (2.4%)

Figure 1. Bivariate density map of otolaryngology physicians and APPs per 100,000 people in each county (n=3,142). Otolaryngology APPs are 6% more likely to practice in rural settings compared with physicians. However, there is no association between state laws allowing NP independent practice and the proportion of rural NPs.

being referred for problems often handled by primary care providers. As labor shortages and capacity strain have affected the healthcare workforce, both referral patterns and otolaryngology practice have been affected. If some of these trends prove secular, then APPs may assume growing importance in absorbing pent-up demand for care and addressing access for both evaluation and management as well as procedural services.

Types of APPs

Despite differences in governance and education, PAs and NPs overlap in scope of practice within otolaryngology. NPs are registered nurses who have undergone additional master's or doctoral level training and education, while PAs complete a master's degree. NPs are governed by a joint committee between the state medical board and nursing board, and PAs are governed by state medical boards. Each state sets the scope of practice standards, with NPs having independent practice authority in 25 states and the District of Columbia. PAs practice under physician supervision but may see patients and bill independently based on state rules.[7] Both NPs and PAs have prescribing authority in all states.

From 2012 to 2017, there were no differences in the proportion of NPs and PAs

employed by otolaryngology practices (63% PAs in 2012 and 67% in 2017).[6] Moreover, 69% of pediatric otolaryngology division chiefs reported no difference in the duties between NPs and PAs on their teams.[3] There have been few studies evaluating the quality of care provided by otolaryngology physicians versus APPs, although previous studies have shown evidence of differences in physician versus NP antibiotic prescribing patterns for pediatric upper respiratory infections.[8]

Payers reimburse practices for PA or NP services at 85% of the fee schedule for physician services under direct billing. With "incident to" billing, the physician bills and collects 100% of allowable reimbursement; this type of billing can be used when an APP sees a patient who has previously been seen by the physician and has a treatment plan determined by the physician. The physician, however, must be located in the same suite, not just in the same building. Billing for shared/split services allows a practice to bill under the physician, but each provider must document the care that they provide and each must personally perform a substantive portion of the visit. Due to the frequency of APPs billing under a physician, it is difficult to know an APP's true involvement in otolaryngology care based on Medicare or other billing database studies alone.

Optimization of APPs

With specialty-specific training, APPs can perform and independently bill for a wide variety of otolaryngology care and procedures either completely independent of physicians or with physician supervision based on state rules. The Mayo Clinic in Arizona was one of the first institutions to offer advanced otolaryngology clinical training to APPs with the creation of a PA fellowship in 2006.[9] As more APPs gain clinical training and otolaryngology experience, the role of APPs in care teams has evolved rapidly. APP practice models include fully integrated care teams, collaborative practice with direct supervision, hospital-based inpatient practice, operating room surgical assistance, semiautonomous practice, and independent practice.

Independent practice models, where APPs see patients with little to no direct involvement of a supervising physician, are increasingly common. While these models have the potential to optimize efficiency while providing quality care, full optimization can only be achieved when APPs are members of a physician-led team. Independent models may be fully independent (clinics at a different place or time from the supervising physician, if one is required by state rules) or concurrent (separate roster of clinic patients at the same time and physical location as a supervising physician). In tertiary care centers, the concurrent model has been utilized wherein APPs see a separate roster of patients that requires continued surveillance, initial triage, or medical management; the supervising physician sees a different roster of clinic patients but is immediately available for consultation or even to take over care, if need arises. Dartmouth-Hitchcock Medical Center found that incorporating APPs into head and neck cancer care increased access for new patients, decreased overbooking, and resulted in equal satisfaction among patients seeing an APP versus a surgeon.[10] Physician productivity was unchanged. Mayo Arizona found that creating an independent model for a rhinology clinic led to a 200% increase in clinic revenue with increased staff satisfaction.[11]

Although no single model is appropriate for all practice types or geographic locations, incorporating APPs can improve patient access to specialty care and patient satisfaction.[7] Creating a workflow model to maximize reimbursement rates can improve the revenue of a practice. APPs can also increase surgeon's availability for consults, referrals, surgical cases, and procedures. As the demand for specialty services continues to exceed the physician workforce capacity, especially in rural areas, APPs will play an increasing role in providing otolaryngology care. ■

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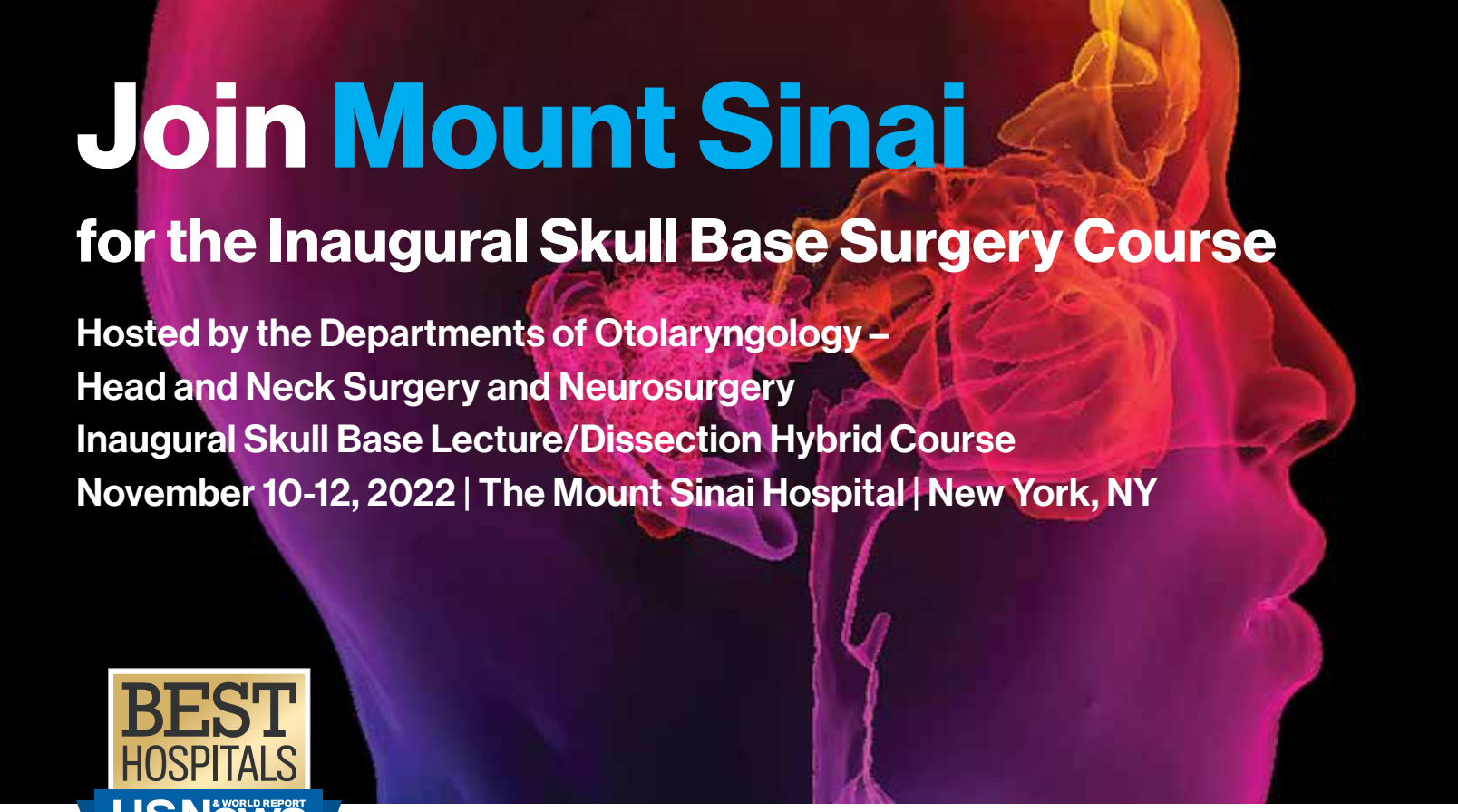

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WE FIND A WAY

Mount Sinai New York

Surgeon Well-Being: Individual, Collegial, and Organizational Perspectives

Jo A. Shapiro, MD, and **David J. Brown, MD**

In this article, we offer a framework for initiating and sustaining efforts to address surgeons' well-being.

It is now widely recognized that our well-being as surgeons is critical to us as well as to society for many reasons, such as workforce retention, morale, and productivity; patient safety and quality; and the clinical learning environment. Even if our well-being was not correlated with any such benefits to society, we still deserve, as does everyone, a workplace that allows us to connect to the meaning of our work and supports us as individuals.

Unfortunately, we now know that there is a crisis of well-being in medicine. This is manifested in persistently high rates of physician burnout, depression, and even suicide. Some argue that all of this is due to a lack of fortitude in surgeons today. We strenuously disagree. Although these are not new problems, the stressors in our profession have significantly increased and exacerbated the problems. For example, although duty hour restrictions have helped with sleep deprivation, the intensity and pace of our work has so dramatically increased that the actual work required is of much higher intensity and volume than in years past. The proportion of time spent on meaningful activities, such as direct patient care, has decreased while the administrative aspects of work, such as documentation, have astronomically increased.

Societal expectations of cures as well as intolerance of fallibility have put excessive pressure on us. Disruptive, racist, sexist, or harassing behaviors—from within healthcare providers but also from patients toward healthcare providers—are prevalent. Larger challenges such as healthcare disparities, which have always been present, have also increased in frequency and severity. Some might argue that these disparities have always existed in the same (or higher severity and frequency) but that our awareness and our

acknowledgment of their existences has increased. In short, we as individuals are not the problem.

So how do we meet the challenges to our well-being? Most healthcare organizations have been trying to address these challenges by decreasing burnout and improving well-being. These disparate efforts can be confusing and even lead to cynicism when any one effort is perceived to fail to deliver on its promises. We would like to offer a framework to help surgeons participate in, develop, innovate, and assess various approaches to improving our well-being. We will describe the framework and then illustrate how some specific initiatives fit into that framework.

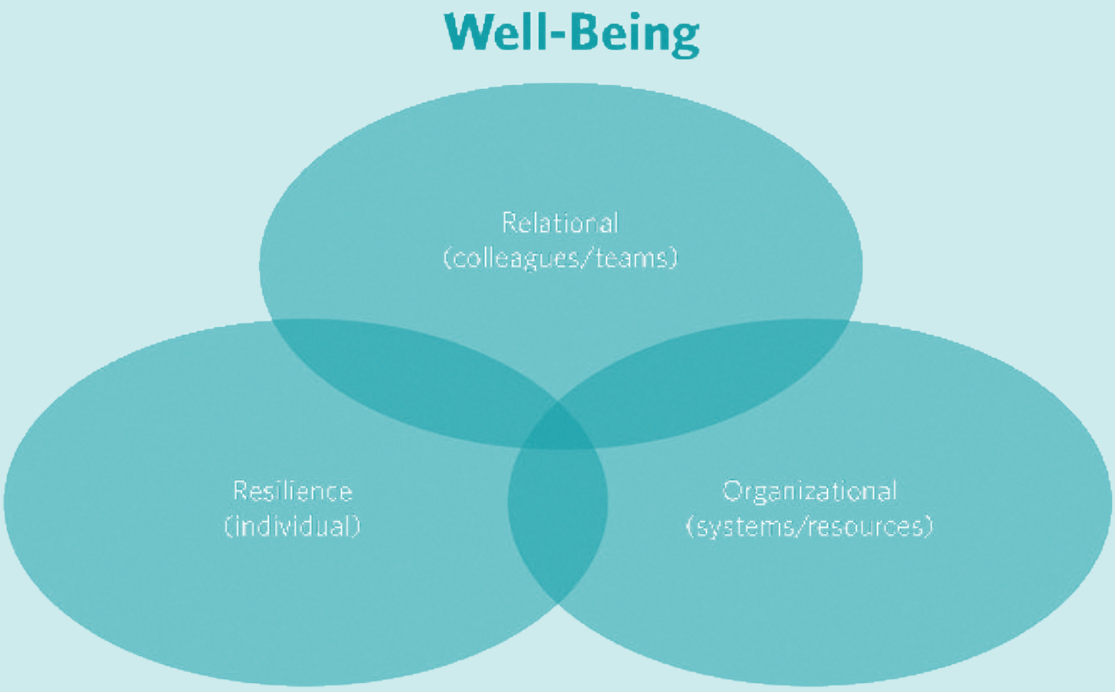
Let us start with the premise that no single well-being initiative is a panacea, and few efforts will bear fruit in a tight timeframe. In addition, it is difficult to rigorously study initiatives because of the confounding variables and long time periods required to measure sustained outcomes. That said, we are all called to action given the high stakes involved if we do not make changes to the current state. **Inaction is not an option.**

The framework can be visualized as three overlapping Venn diagram circles, each one describing the following initiatives that address different aspects of well-being:

- Individual (resilience)
- Collegial (sense of community)
- Organizational (overarching workplace initiatives and resource allocation)

Individual: These efforts are directed toward facilitating our individual resilience, which can be defined as growth through adversity. There are certain stressors that we as surgeons are highly likely to face at some point in our careers, including medical errors, distressing patient outcomes even with excellent care, litigation, patient aggression, and illness of a colleague. Layered on top of these are chronic stressors, such as mental and physical health disorders, illness, financial pressures, disruptive behaviors, racism, harassment, healthcare disparities for our patients, etc. Most of these are not entirely under our control to prevent, so we need to focus on how we react to them. Resilience strategies include self-care practices, such as exercise and healthy diet and stress reduction approaches, such as meditation and gratitude practices. It is important to state, however, that the responsibility for well-being cannot rest on our individual shoulders. It is unfair for us to individually bear the burden for some aspects of surgery that need wider approaches.

Collegial: Most of us derive significant joy from the support and sense of community that come from our colleagues. We need only think back to residency when, despite the responsibilities and heavy workloads, we felt buoyed by our fellow residents and mentors. Once we begin our lives post-training, however, there are fewer opportunities to connect with colleagues. In addition, many institutions have eliminated gathering spaces, such as physicians' and/or surgeons' lounges and cafeteria sections. Practicing surgery



can be quite isolating, perhaps more so for rural surgeons and those practicing in more isolated settings. Some well-being initiatives have provided opportunities for colleagues to gather and reconnect, such as monthly dinners with structured discussions.

Organizational: Clearly, there are many aspects of practicing surgery that depend on our organizations, including workflow issues, documentation burdens, electronic health record structures, resource allocation, equipment and infrastructure, and addressing racism, discrimination, disruptive behaviors, and other threats to workplace safety, both psychological and physical. Local and national organizations need to take responsibility for leading efforts to address these challenges.

We will use three examples of well-being challenges and show how specific initiatives to address these challenges fit into the framework detailed above.

Acute Stressors: As mentioned, the practice of surgery is both highly rewarding and, at times, highly stressful. Acute events such as medical errors, litigation, and patient aggression are known to cause significant emotional impact on the involved clinicians. Research has shown that in response to such stressors, physicians want to be supported by physician colleagues rather than mental health providers. In response, many organizations have developed peer support programs to provide proactive outreach for either one-on-one or group peer support. Looking at the framework of well-being initiatives, peer support sits at the intersection of the three circles: aiding individual resilience by helping peers navigate and strategize in the face of adversity, promoting collegiality by having the support come from a colleague who understands the pain, and organizational responsibility by having the institution resource the peer support program as well as responding to systems issues that may become evident in the peer support intervention.

Diversity, Equity, and Inclusion Challenges: The COVID-19 pandemic highlighted numerous inequities in addition to healthcare disparities. Women were disproportionately tasked with childcare, homecare, and homeschooling in addition to their professional careers. Minoritized individuals shouldered the additional burdens of advocating for patient equity and doing most of the diversity, equity, and inclusion education (formally and informally), all while experiencing bias, discrimination, harassment, homophobia, and racism in their personal and professional lives. These additional "taxes" decrease our well-being.

Implicit biases are ubiquitous in our society, career pathways, and work environments. These biases can obstruct advancement, forcing woman and minoritized individuals to work harder to achieve their goals and aspirations. This adds extra stress to a profession that is experiencing significant burnout at baseline. Implicit bias training is only the first step in raising the awareness of our biases. We must continue to acknowledge that biases exist, hold ourselves and others accountable for biased practices, and actively model behaviors and actions that combat their negative influences.

Harassment and microaggressions continue to be experienced in the workplace and are perpetrated by peers, superiors, learners, and patients. These unwanted aggressions decrease our mental health and increase burnout. Although there are tools and tactics for recipients to respond to harassment and microaggressions, the response and restoration burden cannot only be on the target, but also needs the support of allies to put into action the skills learned from bystander/upstander trainings. Additionally, institutions can help by utilizing easy-access reporting systems that are free from retaliation and accountable to timely assessments, professional development, corrective actions, and positive culture reinforcements.

One opportunity to increase well-being is to build a sense of belonging, which comprises feelings of acceptance, connectedness, and being valued by the group. Belonging is not only associated with increased well-being, but it also increases employee engagement, performance, and retention. Teams and institutions can support belonging by ensuring psychological and emotional safety, creating an environment that is welcoming, celebrating the unique contributions from each person, and honoring diversity, equity, and inclusion at all times.

Cultural humility enhances belonging and well-being by engaging others in humble, authentic, and mindful active listening. The term was coined in 1998 by Melanie Tervalon, MD, MPH, and Jann Murray-García, MD, MPH, as a tool to positively enhance the relationship between physicians and patients of diverse racial and ethnic backgrounds. Cultural humility is a lifelong commitment to learning and self-reflection that recognizes, challenges, and mitigates power imbalances while building mutual respect, partnership, and trust. It is now being practiced in the workplace and leads to better communication, increased well-being, improved mental health, and reduced interpersonal conflict.

Musculoskeletal Injuries: We know that surgeons are at an elevated risk for occupational musculoskeletal injuries, including cervical and lumbar spine, as well as carpal tunnel. In our AAO-HNSF 2021 Annual Meeting Panel Presentation addressing well-being, we invited a presentation by a physical therapist who has expertise in surgeon musculoskeletal health. Recommendations such as preventative stretching, strengthening, and breathing exercises fall into the individual sphere. Organizational responsibilities include providing education to all surgeons, including trainees, on mitigating the risk of musculoskeletal injuries; providing ergonomically sound equipment, including meeting the needs of women surgeons and others with varying body types such as hand size; and facilitating treatment access to surgeons who sustain musculoskeletal injuries.

Supporting surgeons' well-being and decreasing burnout require sustained and multipronged efforts. It is our hope that as individuals, colleagues, and organizations, we will all continue to find ways to engage and innovate in various well-being initiatives. ■

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OUT OF COMMITTEE: Voice

Upper Aerodigestive Tract Manifestations of COVID-19: Voice, Airway, and Swallowing

Sandra L. Ettema, MD, PhD, CCC-SLP, Diana N. Kirke, MD, and **Karla F. O'Dell, MD**

VOICE

What We Know

COVID-19, like other upper respiratory tract infections that cause widespread airway inflammation and possible neurotropism of the vagus nerve, can affect the voice. The rate of dysphonia is widely variable, quoted at 25% of patients with mild-to-moderate disease to 75% of those with severe disease requiring intubation.[1] Increasing age appears to be a significant factor in the development of dysphonia.[2] Finally, duration has been reported as greater than two weeks in 47.1% but greater than a month in only 15.7%.[3]

What We Are Seeing

Dysphonia from COVID-19 can be related directly to the sequelae from intubation or can also occur in those who were not intubated. It generally manifests as voice fatigue, with one reported rate of 26.8%, and less rarely dyspnea.[3] Dysphonia in those previously intubated is more likely related to structural and anatomic inflammatory changes of the glottis, such as arytenoid ankylosis and posterior glottic stenosis.[4] In those who have not been intubated, the underlying cause of dysphonia appears to be related to a neurogenic etiology, such as vocal fold paralysis, paresis, and compensatory muscle tension dysphonia.[4,5]

What to Look for

If a patient has persistent dysphonia following infection with COVID-19, they should be promptly assessed by an otolaryngologist and speech language pathologist (SLP). Subjective and objective acoustic measures should be obtained at baseline, where possible. If dysphonia is persistent, the patient should be assessed via videostroboscopic assessment. Interventions are targeted toward the underlying cause and include voice therapy, in-office procedures, such as injection augmentation, and operative procedures aimed at addressing glottic stenosis.

What We Don't Know

Intubation-related dysphonia is no doubt related to the inflammatory sequelae of pressure ischemia; however, whether this is worse in the COVID-19-affected patient has still yet to be elucidated. In those with non-intubation dysphonia, multiple hypotheses have been proposed and are largely centered on post-viral vagal neuropathy (PVVN). It is now well known that COVID-19 enters cells of the respiratory tract by attaching to angiotensin converting enzyme 2 (ACE-2) transmembrane protease serine 2 (TMPRSS2) proteins. Being that these receptors are found throughout the upper respiratory tract, including the vocal cords, is an indication to causality of the neurological dysfunction but is an area for further investigation.[4]

AIRWAY

What We Know

COVID-19 can cause detrimental involvement of the lower respiratory tract with interstitial pneumonia requiring prolonged endotracheal intubation and mechanical ventilation with high positive end-expiratory pressure through an endotracheal tube (ETT) and often in prone positioning. Prior to COVID-19, use of smaller ETTs, shorter intubation periods, and a close monitoring of cuff pressures were advocated. Clinical practice with COVID-19 patients was to postpone tracheostomy until the patient no longer needed prone positioning as the fear of accidental decannulation and chance cross infection of healthcare professionals was

concerning.[6,7] The degree of laryngeal airway injury depends on size of ETT, duration of intubation, and any comorbidities, including cardiovascular issues, diabetes, obesity, shock, or other ischemic conditions or concomitant infections.

What We Are Seeing

Patients who had COVID-19 and required intubation and/or tracheostomy and possibly prone ventilation, high-dose steroids, feeding tube, and/or impaired wound healing from radiation/diabetes and other comorbidities are now often seen weeks to months after extubation or decannulation for acute dyspnea. They complain of shortness of breath with exertion and even rest, stridor, dysphagia, dry cough, globus, and hoarseness. These patients are at highest risk for these symptoms and development of laryngotracheal stenosis and other airway complications.[6,8,9]

What to Look for

As otolaryngologists, we need to maintain a high level of suspicion for the patients with a history of COVID-19 who were mechanically ventilated with or without tracheostomy post-hospitalization for laryngeal/airway injury and symptoms. There is often a delay in being evaluated by an airway specialist as many are being evaluated by primary care, pulmonology, cardiology, internists, ER physicians, and various allied health professionals first. Our European colleagues predicted an increased number of patients with COVID-19 to have symptoms of airway stenosis and provided direction for automatic follow-up with an otolaryngologist.[6] Early endoscopic evaluation and treatment (e.g., debride necrotic tissue, inhaled steroids, antibiotics with anti-inflammatory properties, early dilation) improve the outcome of post-intubation airway stenosis.[10-14] Multidisciplinary communication is imperative to heighten awareness of laryngotracheal airway issues and lower the threshold for consultation to an otolaryngologist for an airway evaluation.

What We Don't Know

It is difficult to know if the airway symptoms in patients with COVID-19 are due to entities we are currently aware of in our knowledge of airway complaints. For example, we are aware increasing cuff pressures and size of ETT can lead to ischemia and airway stenosis, but is it worse if the patient is prone and has COVID-19?[6] It has also been pointed out that COVID-19 laryngitis and laryngeal edema may be a factor in prolonged intubation in these patients, as well as nasogastric tube placement.[15,16] Future prospective studies will allow us to determine the role these aspects have on long-term outcomes of airway management in surviving post-COVID patients.

SWALLOWING

What We Know

Dysphagia occurs in 20%-60% of intensive care unit (ICU) patients with acute respiratory distress syndrome (ARDS) requiring intubation with prolonged mechanical ventilation.[17,18] The cause of post-intubation dysphagia is multifactorial, related to sarcopenia, critical illness polyneuropathy, alteration in coordination of swallowing, and respiration from pulmonary disease and direct laryngeal trauma, including edema and vocal fold immobility.[17] The duration of intubation can increase the incidence of dysphagia. Tracheostomy was often delayed in patients with COVID pneumonia resulting in longer intubation duration.[7] Post-COVID-19 patients often have reduced lung function and increased discoordination of respiration and swallowing resulting in worse dysphagia. For these reasons, it is thought that dysphagia after severe COVID-19 infection may be higher than dysphagia after prolonged intubation from other causes.[19]

Patients with COVID-19 infection can experience long-lasting neurological symptoms, including loss of smell and taste. Once again, it has been shown that the pharynx and larynx surface cells express ACE-2 receptor and TMPRSS2 proteins, which are an entry route for the virus and may have neurosensory alteration resulting in symptoms of dysphagia.[20]

What We Are Seeing

Dysphagia has been reported as a post-COVID-19 symptom in patients with mild-to-moderate infection and even after resolution of the acute infection. Several survey studies have shown dysphagia to be common with 74% of patients reporting some swallowing symptoms during the initial infection. This percentage reduced to 23% at one-month post-infection.[21] In another multicountry survey study on 3,752 patients, 28 days after first symptom 30% of patients reported difficulty swallowing and globus sensation.[22] Sensation of food sticking in the throat and difficulty swallowing liquids were reported as the two most common swallowing-related complaints.[23]

What to Look for

Patients with COVID-19 infection requiring intubation should be screened for dysphagia prior to initiating a diet. SLP should be consulted for evaluation and diagnostic studies as indicated. Patients presenting to outpatient clinics with symptoms of globus sensation and dysphagia following COVID-19 infection should be counselled that these symptoms have been reported for at least 30 days after the initial onset. Patients should be screened for red flag symptoms, such as weight loss, modifying diet because of difficulty swallowing, and overt symptoms of aspiration.

What We Don't Know

Although it has been postulated that dysphagia in mild-to-moderate COVID-19 may be related in part to a neurosensory disruption, such as loss of taste and smell, it is unclear if this is truly the mechanism. It is unclear also if there is any specific treatment for post-COVID-19 dysphagia. It is not known how long dysphagia symptoms persist after infection as there are no studies that investigate long-term dysphagia symptoms. Prospective studies that define the specific swallowing-related symptoms patients experience with diagnostic results and timeline for resolution of symptoms are warranted. ■

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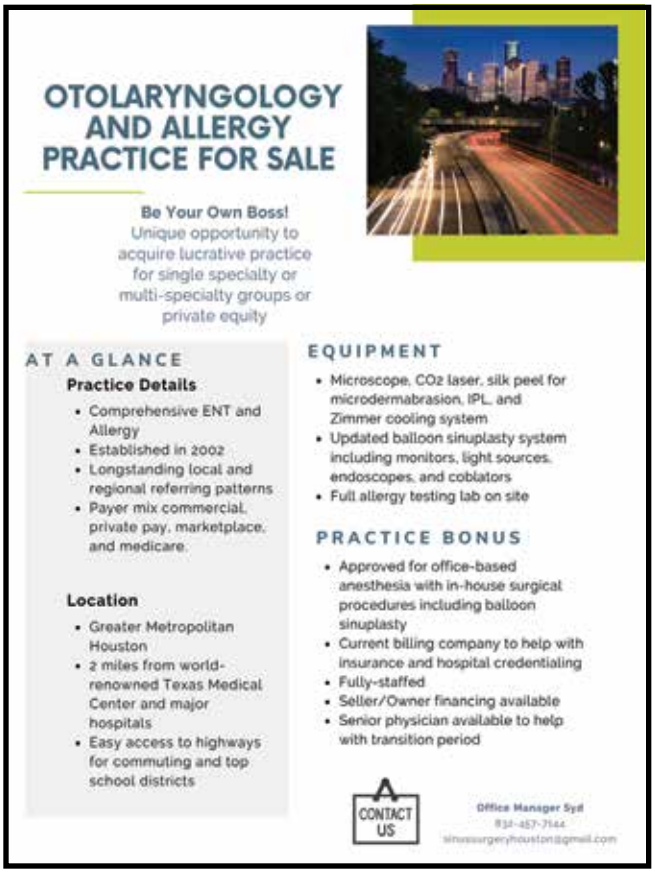

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We are looking for a Neurotologist to join our practice. Currently, we have a neuro otology clinic and one Neurotologist. Our service is overflowing with patients and we want someone who aligns with our values to join our team and help serve our population of patients.

Please inquire directly by emailing Deborah Porter, Human Resources Manager at **hrmanager@entmds.net**. Please submit a Curriculum Vitae to officially be considered for the position. The Human Resource Manager can also be reached by calling the office number at extension 1157.

3801 University Drive Fairfax, VA 22030
Phone: 703-383-8130
Email: hrmanager@entmds.net

Join Our Coordinated Multispecialty Care Team

OTOLARYNGOLOGISTS
Full Time Opportunities in NJ & NY

If you are looking for a collaborative, dynamic practice environment where you can learn, grow, and excel in providing integrated, multidisciplinary, patient centered care, then the Summit Health family is the place to be! **We are seeking Board Certified/Board Eligible Otolaryngologists.**

About Us

Summit Health is a physician-driven, patient-centric network committed to simplifying the complexities of health care and bringing a more connected kind of care. Formed by the 2019 merger between Summit Medical Group, one of the nation's premier inde-pendent physician-governed multispecialty medical groups, and CityMD, the leading urgent care provider in the New York metro area, Summit Health delivers a more intuitive, comprehensive, and responsive care experience for every stage of life and health condi-tion through high-quality primary, specialty, and urgent care.

In 2022, **Westmed Medical Group**, a multispecialty practice, and **New Jersey Urology**, one of the leading urology practices in the United States, partnered with us to extend our services. Summit Health has more than 2,500 providers, 12,000 employees, and over 340 locations in New Jersey, New York, Connecticut, Pennsylvania, and Central Oregon. For more information, please visit **summithealth.com.**

Benefits We Offer

- Competitive compensation
- Shareholder opportunity
- Comprehensive benefits package
- Generous CME funding
- Opportunities for professional growth
- Complete administrative and care management support

If you are an interested candidate, please reach out to our recruitment team email: **providerrecruitment@summithealth.com**

To apply and explore opportunities, visit our career page: **joinsummithealth.com**

Or scan:

Summit Health

LSU Health SHREVEPORT

Department of Otolaryngology-Head and Neck Surgery

ACADEMIC OPPORTUNITIES

The Department of Otolaryngology/HNS at LSU Health Shreveport is experiencing growth and seeking BC/BE applicants to join a vibrant department with a good work/life balance. Candidates must demonstrate excellence in patient care, teaching medical students and residents, and research. The department has 15 residents and two fellows. Ochsner LSU-Health is a tertiary care center and level 1 trauma center. It is the only Academic Center in Northwest LA and draws patients from the Tristate area of Louisiana, East Texas, and South Arkansas (Ark-La-Tex region). Research options both clinical and translational are available if desired. Current openings are:

Otologist/Neuro-otologist: Seeking a fellowship trained candidate who is interested in growing a robust practice and pursuing leadership opportunities. There is a team of well-trained audiologists & support staff in the dept. This is a full-time, academic positions at the rank of Assistant, Associate, or Professor that offer a competitive and desirable compensation/benefits package commensurate with training, experience, and market demand.
To apply for this position please click the link below:
https://www.lsuhsc.edu/shv/CareerOpportunities/Home/Detail/3889

Comprehensive ENT with interest in sleep (preferable): Ochsner-LSU Health has expanded their primary care referrals with significant expansion of ambulatory clinic locations and a growing need for a Comprehensive Otolaryngologist. This is a full-time, academic positions at the rank of Assistant, Associate, or Professor that offer a competitive and desirable compensation/benefits package commensurate with training, experience, and market demand.
To apply for this position please click the link below:
https://www.lsuhsc.edu/shv/CareerOpportunities/Home/Detail/3890

Pediatric Otolaryngology: Candidate must be fellowship trained in Complex Pediatric Otolaryngology. A unique opportunity to join a robust established practice treating children with all aspects of pediatric ENT pathology. We are particularly interested in individuals with expertise in complex airway management. This is a full-time, academic positions at the rank of Assistant, Associate, or Professor that offer a competitive and desirable compensation/benefits package commensurate with training, experience, and market demand.
To apply for this position please click the link below:
https://www.lsuhsc.edu/shv/CareerOpportunities/Home/Detail/3891

Once you have applied, please complete the following:
Please send curriculum vitae, a statement of current interests, and names of three references to:
Cherie-Ann Nathan, MD, FACS
Professor and Chair of Oto/HNS,
Director of Head and Neck Surgical Oncology
1501 Kings Highway, 9-203
Shreveport, LA 71103-33932
Telephone: 318-675-6262 Fax: 318-675-6260 E-mail: cherieann.nathan@lsuhs.edu

LSU Health – Shreveport is an equal opportunity employer, and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law.

Chair, Department of Otolaryngology - Head & Neck Surgery

Henry Ford Health seeks a Chair for the Department of Otolaryngology - Head & Neck Surgery

The successful candidate will be responsible for clinical, educational and research activities of the department including responsibility for the Division of Audiology, Division of Oromaxillofacial Surgery, and the Section of General Dentistry.

HENRY FORD HEALTH

To apply

Submit an updated Curriculum Vitae (CV) and Letter of Interest to Larisa Pistin at **lpistin1@hfhs.org**.

Highlights of the Department include:

- Otolaryngology services provided at five Henry Ford Health hospitals and eight Outpatient Clinics
- More than 3,500 Surgeries annually
- More than 68,000 outpatient visits
- 26 Otolaryngologists in the Department, 4 Oral & Maxillofacial Surgeon, 2 General Hospital Dentists, 23 Audiologists, 4 Audiology fellows, 10 Advanced Practice Providers, 13 Otolaryngology Residents, 1 Head and Neck Cancer Fellow
- More than $36M in patient revenue
- Academic appointment through Michigan State University as part of the Henry Ford Health + Michigan State University Health Sciences Center

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

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

BC/BE General Otolaryngologist

The Ohio State Medical Center is expanding its ambulatory clinical sites. As a result, the Department is seeking board certified/board eligible General Otolaryngologists to join the top-ranked Department of Otolaryngology – Head and Neck Surgery at The Ohio State University. Currently, our general division consists of two general otolaryngologists and two nurse practitioners. Applicants must demonstrate excellence in patient care, research, teaching, and leadership. Experience/interest in sleep surgery is a plus as we continue to grow as one of the leading sleep surgery sites in the nation. This is an outstanding opportunity to build a diverse practice and work with an exceptional team.

Located in the heart of Ohio, Columbus is the fastest growing city in the Midwest and offers a population of over 1.5 million people. Voted as one of the most livable cities in the USA, Columbus has excellent cultural, sporting, and family activities.

To build a diverse and inclusive workforce, all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status or protected veteran status. The Ohio State University Wexner Medical Center is an Equal Opportunity/Affirmative Action employer.

Send letter of interest and CV to:
James Rocco, MD, PhD, Professor and Chair
The Ohio State University Department of Otolaryngology
915 Olentangy River Rd. Suite 4000
Columbus, Ohio 43212

Contact the Department Administrator via
Email: mark.inman@osumc.edu
Fax: 614-293-7292 or
Phone: 614-293-3470

GENERAL OTOLARYNGOLOGIST OPPORTUNITY

Columbus, Ohio

SCAN TO APPLY

Ohio ENT & Allergy Physicians (OENTA), the largest independent ENT and Allergy practice in Ohio, has openings in our Otolaryngology division. We provide exceptional care at 11 offices by 28 physicians throughout central Ohio. OENTA offers a full range of pediatric and adult ENT services, including audiology and vestibular services, laryngology, voice pathology, facial plastics, CT scanning, hearing aid dispensing, and an ENT-dedicated ambulatory surgery center. In addition, a structured path to partnership is available that includes potential opportunities for ownership in retail hearing aid business, ambulatory surgery center, and real estate.

Columbus, Ohio, is one of America's fastest-growing cities with a lot to do, including major sports, great golf, beautiful arts, and excellent schools. In addition, Columbus has a strong economy based primarily on banking, insurance, government, and education.

REQUIREMENTS:

- Board certified or eligible
- Excellent communication and interpersonal skills
- Graduate from an accredited residency program in ENT

IF INTERESTED, APPLY ONLINE OR CONTACT
KELLY PASCO, HR DIRECTOR
OHIO ENT & ALLERGY PHYSICIANS
PHONE: (614) 273-2253 / EMAIL: KELLYPASCO@OENTA.COM
APPLY HERE: https://bit.ly/ENTphysician

Ohio ENT & Allergy Physicians
OhioENTandAllergy.com

Avera

Avera Medical Group Otolaryngology – Head & Neck Surgery
is expanding with subspecialty opportunities in
LARYNGOLOGY
RHINOLOGY

AMG Otolaryngology – Head & Neck Surgery provides subspecialty ENT care for the entire Avera network at McKennan Hospital & University Health Center in Sioux Falls, South Dakota

- 545-bed non-profit Catholic tertiary care referral center for SD and the surrounding areas of MN, IA, NE and ND
- Large network of referrals from regional primary care, ENT, and other specialty physicians
- State-of-the-art technology, senior mentors, and enthusiastic collaborators in a collegial environment
- Robust translational and clinical research infrastructure and support
- Commitment to drive improvement in patient care and clinical outcomes locally and regionally
- Opportunities for academic appointment and teaching through University of South Dakota School of Medicine
- Excellent compensation and benefit package, 96% retention rate

Sioux Falls, SD has been recognized as one of the most business-friendly communities in the nation, as well as a great place to raise a family. Most recently, Sioux Falls was recognized #1 in the nation for young professionals (SmartAsset 5/21). South Dakota has no state income tax!

Suzette Hohwieler, Physician Recruiter, at 605-360-2997 or email Suzette.Hohwieler@Avera.org or Mark Jameson, MD PhD, Medical Director for Otolaryngology at Mark.Jameson@Avera.org

See us at the AAO-HNSF 2022 Annual Meeting & OTO Experience booth #2507

Weill Cornell Medicine | NewYork-Presbyterian

Sleep Surgery

in the Department of Otolaryngology – HNS

Weill Cornell Medicine/NewYork-Presbyterian Hospital

The Department of Otolaryngology – Head and Neck Surgery is seeking a Sleep Board-certified Otolaryngologist to lead our Sleep Surgery program, which is already established and active. We were the first program in the region to implant the hypoglossal nerve stimulator device, and we have a strong collaboration with the Adult and Pediatric Sleep Centers at Weill Cornell/NewYork-Presbyterian. We are seeking a candidate to maintain and enhance our clinical and academic programs, and train our residents.

You will be joining a strong and growing Department, with multiple practice sites across New York City. We have many other subspecialty clinical programs, and a highly selective residency program.

We offer a competitive salary and benefits package. You will be employed by Weill Cornell Medical College as a full-time faculty member.

If interested, please contact Victoria General at vig2014@med.cornell.edu

"Diversity is one of Weill Cornell Medicine's core values and is essential to achieving excellence in patient care, research, and education. We welcome applications from candidates who share our commitment to fostering a culture of fairness, equity, and belonging. Weill Cornell Medicine is an Equal Employment Opportunity Employer, providing equal employment opportunities to all qualified applicants without regard to race, sex, sexual orientation, gender identity, national origin, color, age, religion, protected veteran or disability status, or genetic information."

Positions are available at the Assistant or Associate Professor level in the Department of Otolaryngology - Head & Neck Surgery

GENERAL OTOLARYNGOLOGIST

- Part-time appointment at the Medical College of Georgia at Augusta University
- Rank commensurate with experience
- Excellent resources are available

HEAD AND NECK SURGEON

- VA Otolaryngology Division Chief
- Part-time appointment at the Medical College of Georgia at Augusta University
- Rank commensurate with experience
- Excellent resources are available
- Fellowship training required
- Interest in reconstruction preferred

PEDIATRIC OTOLARYNGOLOGIST

- Excellent opportunity at our Children's Hospital of Georgia
- Rank commensurate with experience
- Excellent resources are available
- Fellowship training required

To apply and receive additional information, please contact:
Stil Kountakis, MD, PhD, Professor and Chairman -
skountakis@augusta.edu

Department of Otolaryngology-Head & Neck Surgery
1120 Fifteenth Street, BP-4109
Augusta, Georgia 30912-4060

AUGUSTA UNIVERSITY
MEDICAL COLLEGE OF GEORGIA

Augusta University is an Equal Opportunity, Affirmative Action and Equal Access employer.

UNIVERSITY OF CALIFORNIA – DAVIS

HEAD AND NECK SURGEON - OTOLARYNGOLOGY - The Department of Otolaryngology at the University of California, Davis, School of Medicine, located at the UC Davis Medical Center in Sacramento, California, is seeking a full-time Assistant or Associate Professor in the clinical series to participate in clinical, teaching and research programs. Candidate is required to have an MD degree, be board certified or board eligible in Otolaryngology, and be eligible for a California medical license. Additionally, candidate must have fellowship training in head and neck surgery and, preferably, microvascular training.

In addition to clinical responsibilities, candidate will be expected to fully participate in departmental programs, including teaching of medical students and residents; and must be able to work cooperatively and collegially within a diverse environment.

Qualified applicants should apply online at UC Recruit: **https://recruit.ucdavis.edu/apply/JPF05064** by uploading current curriculum vitae with bibliography, letter of interest, statement of contributions to diversity, and the names and contact information of at least three professional references.

For more information, please contact: Dr. Marianne Abouyared - **mabouyared@ucdavis.edu**, or Dr. Andrew Birkland - **acbirkeland@ucdavis.edu**. For full consideration, applications must be received by June 30th, 2023; however, the position will remain open until filled.

UC Davis commits to inclusion excellence by advancing equity, diversity, and inclusion in all that we do. We are an Affirmative Action/Equal Opportunity employer, and particularly encourage applications from members of historically under-represented racial/ethnic groups, women, individuals with disabilities, veterans, LGBTQ community members, and others who demonstrate the ability to help us achieve our vision of a diverse and inclusive community. For the complete University of California nondiscrimination and affirmative action policy see: **http://policy.ucop.edu/doc/4000376/NondiscrimAffirmAct**.

UC Davis Health welcomes applications from women and under-represented minorities. The University has a strong institutional commitment to the achievement of diversity among its faculty and staff.

Under Federal law, the University of California may employ only individuals who are legally able to work in the United States as established by providing documents as specified in the Immigration Reform and Control Act of 1986. Certain UCSC positions funded by federal contracts or sub-contracts require the selected candidate to pass an E-Verify check. More information is available at: **http://www.uscis.gov/e-verify**.

As a condition of employment, you will be required to comply with the University of California **SARS-CoV-2 (COVID-19) Vaccination Program Policy**. All Covered Individuals under the policy must provide proof of Full Vaccination or, if applicable, submit a request for Exception (based on Medical Exemption, Disability, and/or Religious Objection) or Deferral (based on pregnancy) no later than the applicable deadline. New University of California employees should refer to Appendix F, Section II.C. of the policy for applicable deadlines. (Capitalized terms in this paragraph are defined in the policy.) Federal, state, or local public health directives may impose additional requirements.

UC Davis is a smoke and tobacco-free campus **(http://breathefree.ucdavis.edu/).**

Academic Pediatric Otolaryngologist-HNS
Norfolk, Virginia

The Department of Otolaryngology-Head and Neck Surgery at Eastern Virginia Medical School is recruiting an energetic fellowship-trained pediatric otolaryngologist at the assistant or associate professor level to replace a retiring senior partner in a 4-member group. Candidates should possess advanced skills in open airway surgery. The successful applicant will join a very busy children's hospital-based practice as part of a 17-member full-time academic otolaryngology department. Free-standing children's hospital with busy PICU and NICU, two suburban ambulatory surgery centers with satellite offices to complement tertiary care hospital practice. Fully-accredited otolaryngology residency with additional opportunities to teach medical students, pediatric residents, and family practice residents. Involvement in multidisciplinary aerodigestive, craniofacial, and vascular anomalies programs. Protected research time and graduated administrative departmental responsibilities. Outstanding benefits and very competitive compensation commensurate with experience.

EVMS is an equal opportunity/affirmative action employer of minorities, females, individuals with disabilities and protected veterans and is a drug and tobacco free workplace

Interested candidates must apply online at www.evms.com/careers

Contact:
Craig Derkay, MD, FACS, FAAP
Department of Otolaryngology-HNS, Eastern Virginia Medical School
Children's Hospital of The King's Daughters
601 Children's Lane, 2nd Floor, ENT suite
Norfolk, VA 23507
(757) 668-9853 craig.derkay@chkd.org

Otolaryngologist MD or DO
A growing practice in Phoenix, AZ is looking to expand

- 2 new custom built offices, each with state-of-the-art equipment including in-office CT, sinus navigation and sinus procedure suite, video-stroboscopy, and home sleep study equipment
- Busy and productive audiology department with 2 full-time Au.Ds. Services include VNG testing and hearing aid dispensing
- Allergy testing and sublingual immunotherapy at both locations
- A wellness department focusing on medically-supervised weight loss and non-surgical aesthetics including body-sculpting, injectables, fillers, IV hydration and body composition analysis
- Deep referral base
- ModMed EMR system, in-house billing, credentialing & marketing
- One MD, One PA and 2 NPs, all full time, round out the care team
- Call 1:7, no ER responsibilities
- Procedures performed in the office or ASC setting, with ownership available as practice builds
- The practice seeks a BC/BE Otolaryngologist who is hard-working, motivated and communicates well, to develop the practice with us
- Fellowship experience possible but not required
- Income potential in 90th percentile or higher
- Opportunity to participate in clinical research
- Excellent starting salary with productivity incentive
- Health insurance, 401(k), malpractice, relocation assistance
- Future involvement in ownership is anticipated and encouraged

Contact: Belinda Cano, Practice Administrator
belinda.cano@azdesertent.com 480-388-0063

ARIZONA DESERT
EAR, NOSE & THROAT SPECIALISTS

Buckhead ENT
Ear, Nose & Throat

Now Hiring! We're ready for you!

Busy ENT practice seeking a well-rounded BC/BE Otolaryngologist in Atlanta GA. The practice is well established and fully equipped with state of the art equipment including Video Stroboscopy, Medtronics CT scan, EMR, networked fiberoptic scopes in the exam rooms. Fully equipped allergy and audiology department, AuD audiologist, VNG, ABR, hearing aids. Competitive salary and benefits.

Qualifications:
- GA License
- Board certification or board eligibility in Otolaryngology
- Current and unrestricted Georgia License
- Active and unrestricted DEA license
- Commitment to clinical excellence and compassionate care to patients
- Ability to work well alone and within a team
- Bilingual (English/Spanish) a plus

Interested candidates please send CV to:
Controller@buckheadent.net

UTHealth® Houston
McGovern Medical School

Faculty Position

The Department of Otorhinolaryngology-Head & Neck Surgery at McGovern Medical School (part of The University of Texas Health Science Center at Houston) is recruiting Pediatric ENT faculty. This is a unique opportunity to build a comprehensive Pediatric ENT practice in a large, diverse, and growing metropolitan area. The ideal candidate should be comfortable in providing full-spectrum Pediatric ENT services primarily at our academic medical center location, which includes a clinic and Children's Memorial Herman Hospital.

This position is primarily focused on clinical care and resident education, although opportunities for scholarship are encouraged. Fellowship training in Pediatric ENT is required, and the successful candidate must have certification in complex pediatric otolaryngology or be planning to obtain certification. All applicants should be board-certified or board-eligible in otolaryngology.

Academic appointment commensurate with experience. Excellent salary and benefits. Outstanding opportunities for teaching and research.

Please submit your CV and application here: **www.ent4.med/recruit**

Interest and questions may be directed to:
Zi Yang Jiang, MD (Pediatric ENT Chief)
Department of Otorhinolaryngology-Head & Neck Surgery
McGovern Medical School
The University of Texas Health Science Center at Houston
Phone: 713-500-5414 Fax: 713-383-1410
Email: zi.yang.jiang@uth.tmc.edu

UTHealth Houston is an EEO/AA employer. UTHealth Houston does not discriminate on the basis of race, color, religion, gender, sexual orientation, national origin, genetics, disability, age, or any other basis prohibited by law. EOE/M/F/Disabled/Vet.

Washington University in St. Louis
SCHOOL OF MEDICINE

Otolaryngologist
Department of Otolaryngology- Head and Neck Surgery

The Department of Otolaryngology-Head and Neck Surgery at Washington University School of Medicine in St. Louis, MO is seeking a Board certified or Board eligible physician(s) to provide patient care with a focus in comprehensive otolaryngology. Teaching of residents and medical students is expected. A variety of research opportunities are available. The clinical environment may include the main campus, as well as community locations in West, and/or South St. Louis County but it is expected that the prime focus will be at our North County clinic. Applicants may apply for an assistant, associate or full professor appointment based on prior experience and training. The department has vast opportunity to provide cutting edge patient care in addition to basic, translational and clinical research experience. Collaboration with existing departmental clinical and basic investigators is encouraged. Salary is negotiable and commensurate with rank, training and experience.

Interested candidates should apply at
https://facultyopportunities.wustl.edu.

Dream Opportunity Available NOW!

Fantastic opportunity for a group or solo otolaryngologist. Well established general otolaryngologist of 34 year's retiring and selling practice.

- Located 55 Miles Northeast of San Fernando Valley in Los Angeles County, California
- Practice draws many patients from surrounding communities around the Antelope Valley
- Great area with very little Competition
- Long-term trained staff. Plus, physician Is available to assist during transition
- Private pay insurance -no HMO and Medi-cal

Emphasis On All Aspects of General ENT-Head & Neck Surgery, Including Extensive Allergy Testing with Immunotherapy Therapy.

Audiometric Equipment: Audiometer, ABR/ECOG, Sound Booth, As Well As Operating Microscope Included with practice

CONTACT INFORMATION:
Judy (Office Manager) (661) 406-6505
Email: otorhinman@gmail.com

Full Time Faculty Opportunity
University of Rochester Medical Center

Neurotologist

BC/BE fellowship trained neurotologist at any rank is sought to join four neurotologists on a faculty of twenty-five otolaryngologists. Applicants must contribute to resident and medical student education. Protected research time and resources are available if candidate seeks a career as a clinician-scientist Interest in lateral skull base surgery and adult otology/neurotology desired. Candidate will eventually assume the practice of retiring senior neurotologist.

This is an excellent opportunity to join a robust clinical practice and strong residency training program at the University of Rochester Medical Center. Our department has an established group of academic faculty practicing in all areas of Otolaryngology.

The University of Rochester is committed to fostering, cultivating and preserving a culture of diversity and inclusion. The University believes that a diverse workforce and inclusive workplace culture enhances the performance of our organization and our ability to fulfill our important missions. The University is committed to fostering and supporting a workplace culture inclusive of people regardless of their race, ethnicity, national origin, gender, gender identity, sexual orientation, socio-economic status, marital status, age, physical abilities, political affiliation, religious beliefs or any other non-merit fact, so that all employees feel included, equally valued and supported. The University of Rochester is responsive to the needs of dual career couples.

Interested candidates should send their curriculum vitae and letter of interest to:

Shawn Newlands, M.D., Ph.D., M.B.A., F.A.C.S.
Professor and Chair
Department of Otolaryngology
University of Rochester
601 Elmwood Avenue, Box 629
Rochester, NY 14642
(585) 273-1943
shawn_newlands@urmc.rochester.edu

ENT AND ALLERGY ASSOCIATES, LLP
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FULL TIME SPECIALTY AND SUB-SPECIALTY POSITIONS AVAILABLE AT THE PREEMINENT OTOLARYNGOLOGY PARTNERSHIP IN THE NATION

Here's your opportunity to become a member of ENT and Allergy Associates, LLP (ENTA) and serve patients in state-of-the-art clinical offices in the **Hudson Valley, Metro NYC, Long Island and Central / Northern New Jersey.**

We offer new associates:

- The collegial expertise and guidance of nationally and internationally recognized specialists and subspecialists
- The prestige of an academic institution, without the bureaucracy
- Clinical faculty appointments at renowned tertiary centers including Mount Sinai, Northwell and Montefiore
- A starting salary of $300,000
- A well-traveled road to partnership without buy-ins and buy-outs
- A governance structure that gives you a voice from Day 1, and colleagues who understand there is more to life than just practicing medicine

Our continued growth, coupled with upcoming physician retirements, means opportunity for you!

For more information, contact our President, Robert Green, MD (Rgreen@entandallergy.com) or our Chief Executive Officer, Robert Glazer (Rglazer@entandallergy.com or call 914-490-8880).

PennState Health

WE ARE HIRING

- Pediatric Otolaryngologist
- Facial Plastic and Reconstructive Surgeon
- Otologist/Neurotologist
- General Otolaryngologists

Penn State Health is seeking Otolaryngologists to join our growing team in either academic or community-based settings. Penn State is a multi-hospital health system serving patients and communities across 29 counties in central Pennsylvania. It employs more than 16,500 people system-wide.

For more information, please contact: Ashley Nippert, Physician Recruiter
anippert@pennstatehealth.psu.edu

Penn State Health is fundamentally committed to the diversity of our faculty and staff. We believe diversity is unapologetically expressing itself through every person's perspectives and lived experiences. We are an equal opportunity and affirmative action employer. All qualified applicants will receive consideration for employment without regard to age, color, disability, gender identity or expression, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information.

Suggested billing & coding

We hear it often when practices see our software for the first time. So often, in fact, that we named it. They're called WOW Moments and it's when you realize that you don't have to compromise and live with the limitations of your outdated system any longer.

For Ramie A. Tritt, MD, his WOW Moment was seeing our EHR system automatically suggest codes as he documents:

"Charting is convenient and efficient with EMA, partly due to the suggested coding function, which suggests how a visit might be billed based on my documentation."

- RAMIE A. TRITT, MD, PRESIDENT
ATLANTA ENT

What will your WOW Moment be? Find out at AAO-HNSF, BOOTH #2226

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