

American Academy of Otolaryngology—Head and Neck Surgery November 2013—Vol.32 No.11

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CPT for ENT 46 and 48





First and Only

for rapid and more

Indication

Dymista Nasal Spray, containing an H₁-receptor antagonist and a corticosteroid, is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

Important Safety Information

- Patients may experience somnolence. Caution patients against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery
- Patients should avoid concurrent use of alcohol or other central nervous system (CNS) depressants because additional reductions in alertness and additional impairment of CNS performance may occur
- Because of the inhibitory effect of corticosteroids on wound healing, avoid use in patients with recent nasal ulcers, nasal surgery, or nasal trauma until healed
- Glaucoma, cataracts, and increased intraocular pressure may be associated with nasal corticosteroid use; therefore, close monitoring is warranted in patients with a change in vision and/or with a history of increased intraocular pressure, glaucoma, and/or cataracts
- Patients using corticosteroids may be susceptible to infections and may experience a more serious or even fatal course of chicken pox or measles. Dymista should be used with caution in patients with active or quiescent tuberculosis; fungal, bacterial, viral, or parasitic infections; or ocular herpes simplex

- Systemic corticosteroid effects, such as hypercorticism and adrenal suppression, may occur with very high dosages or at the regular dosage in susceptible individuals. If such changes occur, discontinue Dymista gradually, under medical supervision
- Potent inhibitors of cytochrome P450 (CYP) 3A4 may increase blood levels of fluticasone propionate
- Ritonavir: coadministration is not recommended
- Other potent CYP3A4 inhibitors, such as ketoconazole: use caution with coadministration
- Intranasal corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista
- In clinical trials, the most common adverse reactions that occurred with Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone nasal spray, and vehicle placebo groups, respectively, were dysgeusia (4%, 5%, 1%, <1%), epistaxis (2% for each group), and headache (2%, 2%, 2%, and 1%)
- Pregnancy Category C: based on animal data; may cause fetal harm



complete relief

from seasonal allergy symptoms^{1,2}



*Onset of action was defined as the first timepoint at which Dymista was statistically superior to placebo in the mean change from baseline in instantaneous TNSS and was sustained thereafter.¹ †Change from baseline in instantaneous TNSS following administration.²

Data shown are from study MP 4004. Across the 3 pivotal clinical trials, the improvement with Dymista ranged from 40% to 67% greater than the improvement achieved with either comparator.²

[‡]Change from baseline in the placebo-subtracted mean TNSS for each day (maximum score 24), averaged over the 14-day study period.²

[§] Percent difference represents the improvement in TNSS with Dymista relative to fluticasone propionate or azelastine HCl comparator. The fluticasone propionate and azelastine HCl comparators used the same device and vehicle as Dymista and are not commercially marketed.²

References: 1. Dymista [package insert]. Somerset, NJ: Meda Pharmaceuticals Inc; 2012. **2.** Data on File. Meda Pharmaceuticals Inc. **3.** Marple BF, Fornadley JA, Patel AH, et al. Keys to successful management of patients with allergic rhinitis: focus on patient confidence, compliance, and satisfaction. *Otolaryngol Head Neck Surg.* 2007;136:S107-S124.

Please see Brief Summary of Full Prescribing Information on the following pages.

DYMISTA® (azelastine hydrochloride and fluticasone propionate) Nasal Spray 137 mcg/50 mcg per Spray

www.Dymista.com

DYMISTA (AZELASTINE HYDROCHLORIDE 137 MCG / FLUTICASONE PROPIONATE 50 MCG) NASAL SPRAY

Brief Summary (for Full Prescribing Information, see package insert)

1 INDICATIONS AND USAGE

Dymista Nasal Spray is indicated for the relief of symptoms of seasonal allergic rhinitis in patients 12 years of age and older who require treatment with both azelastine hydrochloride and fluticasone propionate for symptomatic relief.

5 WARNINGS AND PRECAUTIONS

5.1 Somnolence

In clinical trials, the occurrence of somnolence has been reported in some patients (6 of 853 patients) taking Dymista Nasal Spray [*see Adverse Reactions (6.1*]. Patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness and motor coordination such as operating machinery or driving a motor vehicle after administration of Dymista Nasal Spray. Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because additional reductions in alertness and additional impairment of central nervous system performance may occur [*see Drug Interactions (7.1*]].

5.2 Local Nasal Effects

In clinical trials of 2 to 52 weeks' duration, epistaxis was observed more frequently in patients 38 treated with Dymista Nasal Spray than those who received placebo [*see Adverse Reactions* [6]].

Instances of nasal ulceration and nasal septal perforation have been reported in patients following the intranasal application of corticosteroids. There were no instances of nasal ulceration or nasal septal perforation observed in clinical trials with Dymista Nasal Spray. Because of the inhibitory effect of corticosteroids on wound healing, patients who have experienced recent nasal ulcers, nasal surgery, or nasal trauma should not use Dymista Nasal Spray until healing has occurred. In clinical trials with fluticasone propionate administered intranasally, the development of localized infections of the nose and pharynx with *Candida albicans* has occurred. When such an infection develops, it may require treatment with appropriate local therapy and discontinuation of treatment with Dymista Nasal Spray. Patients using Dymista Nasal Spray over several months or longer should be examined periodically for evidence of *Candida* infection or other signs of adverse effects on the nasal mucosa.

5.3 Glaucoma and Cataracts

Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Therefore, close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma, and/or cataracts.

Glaucoma and cataract formation were evaluated with intraocular pressure measurements and slit 56 lamp examinations in a controlled 12-month study in 612 adolescent and adult patients aged 12 years and older with perennial allergic or vasomotor rhinitis (VMR). Of the 612 patients enrolled in the study, 405 were randomized to receive Dymista Nasal Spray (1 spray per nostril twice daily) and 207 were randomized to receive fluticasone propionate nasal spray (2 sprays per nostril once daily). In the Dymista Nasal Spray group, one patient had increased intraocular pressure at month 6. In addition, three patients had evidence of posterior subcapsular cataract at month 6 and one at month 12 (end of treatment). In the fluticasone propionate group, three patients had evidence of posterior subcapsular cataract at

5.4 Immunosuppression

Persons who are using drugs, such as corticosteroids, that suppress the immune system are more susceptible to infections than healthy individuals. Chickenpox and measles, for example, can have a more serious or even fatal course in susceptible children or adults using corticosteroids. In children or adults who have not had these diseases or been properly immunized, particular care should be taken to avoid exposure. How the dose, route, and duration of corticosteroid administration affect the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chickenpox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with pooled intramuscular immunoglobulin 74 (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chickenpox develops, treatment with antiviral agents may be considered.

Corticosteroids should be used with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract; untreated local or systemic fungal or bacterial infections; systemic viral or parasitic infections; or ocular herpes simplex because of the potential for worsening of these infections.

5.5 Hypothalamic-Pituitary-Adrenal (HPA) Axis Effects

When intranasal steroids are used at higher than recommended dosages or in susceptible individuals at recommended dosages, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes occur, the dosage of Dymista Nasal Spray should be discontinued slowly, consistent with accepted procedures for discontinuing oral corticosteroid therapy. The concomitant use of intranasal corticosteroids with other inhaled corticosteroid could increase the risk of signs or symptoms of hypercorticism and/or suppression of the HPA axis. The replacement of a systemic corticosteroid with a topical corticosteroid can be accompanied by signs of adrenal insufficiency, and in addition some patients may experience symptoms of withdrawal, e.g., joint and/or muscular pain, lassitude, and depression. Patients previously treated for prolonged periods with systemic corticosteroids and transferred to topical corticosteroids should be carefully monitored for acute adrenal insufficiency in response to stress. In those patients who have asthma or

other clinical conditions requiring long-term systemic corticosteroid treatment, too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of their symptoms.

5.6 Use of Cytochrome P450 3A4 Inhibitors

Ritonavir and other strong cytochrome P450 3A4 (CYP3A4) inhibitors can significantly increase plasma fluticasone propionate exposure, resulting in significantly reduced serum cortisol concentrations [*see Drug Interactions (7.2) and Clinical Pharmacology (12.3)*]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of Dymista Nasal Spray and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Use caution with the coadministration of Dymista Nasal Spray and other potent CYP3A4 inhibitors, such as ketoconazole [see Drug Interactions (7.2) and Clinical Pharmacology (12.3]].

5.7 Effect on Growth

Corticosteroids may cause a reduction in growth velocity when administered to pediatric patients. Monitor the growth routinely of pediatric patients receiving Dymista Nasal Spray [see Use in Specific Populations (8.4)].

6 ADVERSE REACTIONS

Systemic and local corticosteroid use may result in the following:

- Somnolence [see Warnings and Precautions (5.1)]
- Local nasal effects, including epistaxis, nasal ulceration, nasal septal perforation, impaired wound healing, and *Candida albicans* infection [see Warnings and Precautions (5.2)]
- Cataracts and glaucoma [see Warnings and Precautions (5.3)]
- Immunosuppression [see Warnings and Precautions (5.4)]
- Hypothalamic-pituitary-adrenal (HPA) axis effects, including growth reduction [see Warnings and Precautions (5.5 and 5.7), Use in Specific Populations (8.4)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect rates observed in practice. The safety data described below reflect exposure to Dymista Nasal Spray in 853 patients (12 years of age and older; 36% male and 64% female) with seasonal allergic rhinitis in 3 doubleblind, placebo-controlled clinical trials of 2-week duration. The racial distribution for the 3 clinical trials was 80% white, 16% black, 2% Asian, and 1% other. In the 12-month open-label, active-controlled clinical trial, 404 Asian patients (240 males and 164 females) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray, 1 spray per nostril twice daily.

Adults and Adolescents 12 Years of Age and Older

In the 3 placebo-controlled clinical trials of 2-week duration, 3411 patients with seasonal allergic rhinitis were treated with 1 spray per nostril of Dymista Nasal Spray, azelastine hydrochloride nasal spray, fluticasone propionate nasal spray, or placebo, twice daily. The azelastine hydrochloride and fluticasone propionate comparators use the same vehicle and device as Dymista Nasal Spray and are not commercially marketed. Overall, adverse reactions were 16% in the Dymista Nasal Spray treatment groups, 15% in the azelastine hydrochloride nasal spray groups, 13% in the fluticasone propionate nasal spray groups, and 12% in the placebo groups. Overall, 1% of patients in both the Dymista Nasal Spray and placebo groups discontinued due to adverse reactions.

Table 1 contains adverse reactions reported with frequencies greater than or equal to 2% and more frequently than placebo in patients treated with Dymista Nasal Spray in the seasonal allergic rhinitis controlled clinical trials.

Table 1. Adverse Reactions with >2% Incidence and More Frequently than

Placebo in Placebo-Controlled Trials of 2 Weeks Duration with Dymista Nasal

Spray in Adult and Adolescent Patients With Seasonal Allergic Rhinitis				
	1 spray per nostril twice daily			
	Dymista Nasal Spray	Azelastine Hydrochloride Nasal Spray†	Fluticasone Propionate Nasal Spray†	Vehicle Placebo
	(N=853)*	(N=851)	(N=846)	(N=861)
Dysgeusia	30 (4%)	44 (5%)	4 (1%)	2 (<1%)
Headache	18 (2%)	20 (2%)	20 (2%)	10 (1%)
Epistaxis	16 (2%)	14 (2%)	14 (2%)	15 (2%)

*Safety population N=853, intent-to-treat population N=848

[†]Not commercially marketed

In the above trials, somnolence was reported in <1% of patients treated with Dymista Nasal Spray (6 of 853) or vehicle placebo (1 of 861) [*see Warnings and Precautions (5.1*]].

Long-Term (12-Month) Safety Trial:

In the 12-month, open-label, active-controlled, long-term safety trial, 404 patients (12 years of age and older) with perennial allergic rhinitis or vasomotor rhinitis were treated with Dymista Nasal Spray 1 spray per nostril twice daily and 207 patients were treated with fluticasone propionate nasal spray, 2 sprays per nostril once daily. Overall, adverse reactions were 47% in the Dymista Nasal Spray treatment group and 44% in the fluticasone propionate nasal spray group. The most frequently reported adverse reactions (≥ 2%) with Dymista Nasal Spray were headache, pyrexia, cough, nasal congestion, rhinitis, dysgeusia, viral infection, upper respiratory tract infection, pharyngitis, pain, diarrhea, and epistaxis. In the Dymista Nasal Spray treatment

group, 7 patients (2%) had mild epistaxis and 1 patient (<1%) had moderate epistaxis. In the fluticasone propionate nasal spray treatment group 1 patient (<1%) had mild epistaxis. No patients had reports of severe epistaxis. Focused nasal examinations were performed and no nasal ulcerations or septal perforations were observed. Eleven of 404 patients (3%) treated with Dymista Nasal Spray and 6 of 207 patients (3%) treated with fluticasone propionate nasal spray discontinued from the trial due to adverse events.

7 DRUG INTERACTIONS

No formal drug interaction studies have been performed with Dymista Nasal Spray. The drug interactions of the combination are expected to reflect those of the individual components.

7.1 Central Nervous System Depressants

Concurrent use of Dymista Nasal Spray with alcohol or other central nervous system depressants should be avoided because somnolence and impairment of central nervous system performance may occur [see Warnings and Precautions (5.1)].

7.2 Cytochrome P450 3A4

Ritonavir (a strong CYP3A4 inhibitor) significantly increased plasma fluticasone propionate exposure following administration of fluticasone propionate aqueous nasal spray, resulting in significantly reduced serum cortisol concentrations [*see Clinical Pharmacology (12.3*]]. During postmarketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing syndrome and adrenal suppression. Therefore, coadministration of fluticasone propionate and ritonavir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

Ketoconazole (also a strong CYP3A4 inhibitor), administered in multiple 200 mg doses to steady-state, increased plasma exposure of fluticasone propionate, reduced plasma cortisol AUC, but had no effect on urinary excretion of cortisol, following administration of a single 1000 mcg dose of fluticasone propionate by oral inhalation route.

Caution should be exercised when Dymista Nasal Spray is coadministered with ketoconazole and other known strong CYP3A4 inhibitors.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Dymista Nasal Spray: Teratogenic Effects: Pregnancy Category C:

There are no adequate and well-controlled clinical trials of Dymista Nasal Spray, azelastine hydrochloride only, or fluticasone propionate only in pregnant women. Animal reproductive studies of azelastine hydrochloride and fluticasone propionate in mice, rats, and/or rabbits revealed evidence of teratogenicity as well as other developmental toxic effects. Because animal reproduction studies are not always predictive of human response, Dymista Nasal Spray should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Azelastine hydrochloride: Teratogenic Effects: In mice, azelastine hydrochloride caused embryo-fetal death, malformations (cleft palate; short or absent tail; fused, absent or branched ribs), delayed ossification, and decreased fetal weight at an oral dose approximately 610 times the maximum recommended human daily intranasal dose (MRHDID) in adults (on a mg/m2 basis at a maternal dose of 68.6 mg/kg). This dose also caused maternal toxicity as evidenced by decreased body weight. Neither fetal nor maternal effects occurred at a dose that was approximately 26 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rats, azelastine hydrochloride caused malformations (oligo- and brachydactylia), delayed ossification and skeletal variations, in the absence of maternal toxicity, at an oral dose approximately 530 times the MRHDID in adults (on a mg/m2 basis at a maternal dose of 30 mg/kg). At a dose approximately 1200 times the MRHDID (on a mg/m2 basis at a maternal dose of 68.6 mg/kg), azelastine hydrochloride also caused embryo-fetal death and decreased fetal weight; however, this dose approximately 53 times the MRHDID (on a mg/m2 basis at a maternal effects occurred at a dose approximately 53 times the MRHDID (on a mg/m2 basis at a maternal dose of 3 mg/kg).

In rabbits, azelastine hydrochloride caused abortion, delayed ossification, and decreased fetal weight at oral doses approximately 1100 times the MRHDID in adults (on a mg/ m2 basis at a maternal dose of 30 mg/kg); however, these doses also resulted in severe maternal toxicity. Neither fetal nor maternal effects occurred at a dose approximately 11 times the MRHDID (on a mg/m2 basis at a maternal dose of 0.3 mg/kg).

Fluticasone propionate: Teratogenic Effects: Corticosteroids have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Subcutaneous studies in the mouse and rat at doses approximately equivalent to and 4 times, respectively, the MRHDID in adults (on a mcg/m2 basis at maternal doses of 45 and 100 mcg/kg respectively), revealed fetal toxicity characteristic of potent corticosteroid compounds, including embryonic growth retardation, omphalocele, cleft palate, and retarded cranial ossification.

In the rabbit, fetal weight reduction and cleft palate were observed at a subcutaneous dose less than the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 4 mcg/kg). However, no teratogenic effects were reported at oral doses up to approximately 25 times the MRHDID in adults (on a mcg/m2 basis at a maternal dose of 300 mcg/kg) of fluticasone propionate to the rabbit. No fluticasone propionate was detected in the plasma in this study, consistent with the established low bioavailability following oral administration [see Clinical Pharmacology (12.3]].

Experience with oral corticosteroids since their introduction in pharmacologic, as opposed to physiologic, doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans. In addition, because there is a natural increase in corticosteroid production during pregnancy, most women will require a lower exogenous corticosteroid dose and many will not need corticosteroid treatment during pregnancy.

Nonteratogenic Effects: Fluticasone propionate crossed the placenta following oral administration of approximately 4 and 25 times the MRHDID in adults (on a mcg/m2 basis at maternal doses of 100 mcg/kg and 300 mcg/kg to rats and rabbits, respectively).

8.3 Nursing Mothers

Dymista Nasal Spray: It is not known whether Dymista Nasal Spray is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when Dymista Nasal Spray is administered to a nursing woman. Since there are no data from well-controlled human studies on the use of Dymista Nasal Spray by nursing mothers, based on data from the individual components, a decision should be made whether to discontinue nursing or to discontinue Dymista Nasal Spray, taking into account the importance of Dymista Nasal Spray to the mother.

Azelastine hydrochloride: It is not known if azelastine hydrochloride is excreted in human milk.

Fluticasone propionate: It is not known if fluticasone propionate is excreted in human milk. However, other corticosteroids are excreted in human milk. Subcutaneous administration to lactating rats of 10 mcg/kg of tritiated fluticasone propionate (less than the maximum recommended daily intranasal dose in adults on a mcg/m2 basis) resulted in measurable radioactivity in the milk.

8.4 Pediatric Use

Safety and effectiveness of Dymista Nasal Spray in pediatric patients below the age of 12 years have not been established.

Controlled clinical studies have shown that intranasal corticosteroids may cause a reduction in growth velocity in pediatric patients. This effect has been observed in the absence of laboratory evidence of HPA axis suppression, suggesting that growth velocity is a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The long-term effects of this reduction in growth velocity associated with intranasal corticosteroids, including the impact on final adult height, are unknown. The potential for "catch-up" growth following discontinuation of treatment with intranasal corticosteroids has not been adequately studied. The growth of pediatric patients receiving intranasal corticosteroids, including Dymista Nasal Spray, should be monitored routinely (e.g., via stadiometry). The potential growth effects of prolonged treatment should be weighed against the clinical benefits obtained and the risks/benefits of treatment alternatives.

8.5 Geriatric Use

Clinical trials of Dymista Nasal Spray did not include sufficient numbers of patients 65 years of age and older to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Dymista Nasal Spray: Dymista Nasal Spray contains both azelastine hydrochloride and fluticasone propionate; therefore, the risks associated with overdosage for the individual components described below apply to Dymista Nasal Spray.

Azelastine hydrochloride: There have been no reported overdosages with azelastine hydrochloride. Acute azelastine hydrochloride overdosage by adults with this dosage form is unlikely to result in clinically significant adverse events, other than increased somnolence, since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 23 mg of azelastine hydrochloride. Clinical trials in adults with single doses of the oral formulation of azelastine hydrochloride (up to 16 mg) have not resulted in increased incidence of serious adverse events. General supportive measures should be employed if overdosage occurs. There is no known antidote to Dymista Nasal Spray. Oral ingestion of antihistamines has the potential to cause serious adverse effects in children. Accordingly, Dymista Nasal Spray should be kept out of the reach of children.

Fluticasone propionate: Chronic fluticasone propionate overdosage may result in signs/ symptoms of hypercorticism [*see Warnings and Precautions (5.2*]]. Intranasal administration of 2 mg (10 times the recommended dose) of fluticasone propionate twice daily for 7 days to healthy human volunteers was well tolerated. Single oral fluticasone propionate doses up to 16 mg have been studied in human volunteers with no acute toxic effects reported. Repeat oral doses up to 80 mg daily for 10 days in volunteers and repeat oral doses up to 10 mg daily for 14 days in patients were well tolerated. Adverse reactions were of mild or moderate severity, and incidences were similar in active and placebo treatment groups. Acute overdosage with this dosage form is unlikely since one (1) 23 g bottle of Dymista Nasal Spray contains approximately 8.5 mg of fluticasone propionate.



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Clinical Practice Guideline Summary: Bell's Palsy

This month, the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) published its latest clinical practice guideline, Bell's Palsy, as a supplement to *Otolaryngology–Head and Neck Surgery*.



AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY

David R. Nielsen, MD Executive Vice President, CEO, and Editor, the *Bulletin*

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The Bulletin (ISSN 0731-8359) is published monthly by the American Academy of Otolaryngology—Head and Neck Surgery 1650 Diagonal Road, Alexandria, VA 22314-2857. © Copyright 2013

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On AAO-HNS Membership

originally joined the American Academy of Otolaryngology—Head and Neck Surgery in 1980. Aside from my decision to go to medical school, this was the best decision that I have ever made for my professional development!

As a Resident

My journey with the Academy began when Byron J. Bailey, MD, a past president of the AAO-HNS, sent us as residents to the meeting in Dallas, TX, in 1977. My mentor, the late Cary N. Moon, MD, of Charlottesville, VA, was a candidate for the presidency in 1980 as I completed my residency; he encouraged me to join the Academy. It was a natural extension of my professional growth to join and attend. From the perspective of continuing education and professionalism, there was no question I would join and attend most annual meetings. The fact that the 1980 meeting was in Anaheim, CA, close to Disneyland, which my young family could visit, had nothing to do with the decision.

As a Young Physician

Early on, the main benefit was continuing education and networking, although I am not sure we were using the term then. I joined other specialty-related societies, but none has had the scope or reach of the Academy. My first formal role in the Academy was appointment to the Medical Devices and Drugs Committee in 1985. **Richard L. Mabry, MD**, was the chair and later became a mentor on a number of levels.

Several years later, in 1993, I was placed on the Program Advisory Committee, my first education-related service. It was an honor and privilege to be one of the only committee members in community-based, rather than academic, practice. In the late 1980s, I became interested in the Board of Governors (BOG), since I had done work with the Alabama Society of Otolaryngology and, in 1989, was named to the BOG Socioeconomic and Grassroots Committee.





macrus

Richard W. Waguespack, MD AAO-HNS/F President

At Mid-Career

At this point in my career, my practice was mature enough and children old enough (and my wife understanding enough) for me to continue in Academy volunteerism, mainly education and socioeconomic focused. As my father and my professional mentors had explained and led by example, there was a duty to serve the profession and specialty that had done so much for me and my family. As one works with other like-minded people in the Academy, it reinforces the desire to continue and begin to mentor those who follow. My transition from private to academic medicine simply gives me an added perspective and opportunity to help bring along younger practitioners, from the occasional med student to residents to younger faculty.

At this stage, the need for continuing education is still there and while there are many venues from which to obtain this, the Academy is still the best single source for me and many colleagues, especially general otolaryngologists. In the research, quality, and health policy spheres, no other organization better represents our specialty than the Academy and—to paraphrase **Neil O. Ward, MD, MAL**, another mentor and past president—I serve to the best of my ability at the pleasure of the Academy and Mrs. Waguespack.

9



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'We All Live Downstream'

ow well do we recognize the legacy we inherit from teachers, trainers, mentors, parents, early pioneers in science, or others who have gone before? Whether we speak of our professional life, or our rich cultural heritage, or our political freedom, we stand on the shoulders of giants—of those who blazed the trail or pioneered new ground. To paraphrase the prophet Moses, we all "live in cities we did not build and drink from wells we did not dig." (Deuteronomy 6:10-11)

Is there an implication from this truism for our behavior? Is there a "So what?" buried in this recognition? Besides being grateful or occasionally celebrating or honoring the memory of earlier contributors, mentors, or leaders, are we obligated in any way participate and have a voice in our government.

Part of the obligation we inherit to respond to the legacy of pioneers who preceded us, is the development of our own leadership skills and being true to the values that enrich our lives. As a prominent corporate executive, Andrea Jung describes the feeling in her career that, having been passed over for the CEO position at the company she loved and wanted to remain with and lead, she was offered a more lucrative position as CEO of another company. Sensing that she was in a hurry to advance her career, a friend and board member advised her to stay, with the words, "Follow your compass, not your clock." She loved what her company stood for and the great influence for good it represented. She stated that

...the greater lesson is likewise about legacy: the impact of the lives of our forebearers, and the inescapable influence that flows downstream from our lives and actions.

to act differently or to do something in response to our "inheritance"? I am confident that each of us, without external prompting, would immediately answer with a firm "yes." I believe this from seeing the pioneering spirit being passed from teacher to student; from my observation of the culture of selfless behavior displayed by our members engaged in humanitarian efforts and teaching; from the incontrovertible evidence of your volunteerism, sacrifices, and leadership in advancing the science and the practice of medicine, and of putting your patients' needs first. It shows up in how we parent our children in our families and exercise our right of political engagement, which is the heritage of every American, to

she then realized that she would prefer to be number two in a company with this positive impact on society than to be number one in another company without it. [*True North*, p. 154]

We live in a time of great change and even uncertainty about certain elements regarding the practice of medicine. There is so much focus on what will be different about our future that we spend too little time ensuring what will not change. Being true to our "compass," the one that led us to become physicians and otolaryngologists in the first place, we can assure our patients that providing them with the highest quality of care possible will NOT change. We can assure those we train in our residency programs that this is an incredible specialty with



David R. Yulun MD

David R. Nielsen, MD AAO-HNS/F EVP/CEO

a bright future of innovation, service, and personal satisfaction. We can assure our medical students and those considering medicine as a career that the best years for physicians and medicine are still ahead of us. And, most important, we can assure the nation and the world that the profession of medicine can be trusted with the stewardship of continuing to save lives, reduce pain and suffering, and improve the quality of life for everyone.

Not long ago, I saw a bumper sticker that read, "We all live downstream." While the point of that particular message was an environmental one, the greater lesson is likewise about legacy: the impact of the lives of our forebearers, and the inescapable influence that flows downstream from our lives and actions. I join with you in accepting the challenge of assuring that downstream from our actions, our work, and our lives will be the clear, cool, and refreshing legacy of success in establishing better care, better health, and better lives for everyone. I urge you to use the Academy and Foundation to share your expertise, refresh your knowledge, expand your friendships and associations, hone your leadership skills, recharge your batteries, and renew your enthusiasm for this great profession.

Thanksgiving and the Academy

his is the time of the year we set aside to reflect on our lives. For each of us, Thanksgiving is a personal time to ponder and possibly act on the things we are thankful for. First of all, I would have to be thankful for the life I was given, and the freedoms we hold dear. I have so much to be thankful for. This includes my family, my community (local, state, and national), and my colleagues and staff.

We are people who long to relate to one another. We learn this very early in our lives. We are incredibly dependent for years. Our desire for relationships continues as we make our way through our lives. We continue to learn, all along the journey. Our Academy and Board help us with those self-improvement efforts, to be better physicians and healers.

Where would we all be, without our education, research, and support from our Academy? I started serving within the American Academy of Otolaryngology-Head and Neck Surgery because one of my state colleagues said it needed me and they thought I could do this. I was hesitant, but asked my former vice-chairman if the AAO-HNS needed someone like me. He almost yelled at me on the phone, "Yes," was the answer. I am glad he encouraged me. The otolaryngologists and staff I have met over the years are impressive. Their expertise is wide ranging. They are able to make connections with key decision-makers on the state and national level. They are fiscally responsible and give us quite a return on the cost of our annual membership. They have sought out effective partners, sometimes in surprising corners. They have a near and long-term vision of the specialty and seek out new and effective ways to attain these goals. They also have been encouraging to me at every juncture. They give me great pride in my work with the Academy and its Board of Governors. I feel as if I serve my patients and their families better, by "going to bat" for them on a bigger playing field. I would encourage you all to consider volunteering. It has been rewarding.

We all have realized how difficult it can be for others in the political or healthcare realm (including insurance) to really hear what we are saying as physician leaders. This is another integral part of being patient advocates. Our Academy staff knows the Congressional offices and the Congressional support staff. Their presence is respected and quite effective. Our support of their activities help them forward our message. We have many ways of supporting the AAO-HNS. Giving to the Academy Foundation through the Millennium Society or Hal Foster, MD Endowment Society, among others, can help sustain the work that began so long ago. Another important and fruitful way to support each other is through the ENT PAC, the Academy's Political Action

We all have many gifts. It is up to each person to determine how to use those gifts. Even a small financial gift can make a difference. Don't underestimate your personal contribution.

Committee. Our PAC has a very high success rate for bipartisan support of candidates who understand and support medicine's role. Please look into that as an option as you consider how to best help shape the future of medicine. These are some of the ways you can show your thankfulness. We all have many gifts. It is up to each person to determine how to use those gifts. Even a small financial gift can make a difference. Don't underestimate your personal contribution.

We all have very important stories to tell about thankfulness in our lives.



Joseph E. Hart, MD Waterloo, IA Member, BOG Executive Committee

One of mine was very specific. On my first day in the operating room as an otolaryngology resident, my chairman stopped before a complicated endoscopy case for a cancer patient, and looked at me. He said we should get down on our knees every night to thank God for a state-of-the-art facility, knowledgeable staff, and patients who trust us with their lives. That set the tone for my residency experience.

At many points in my life, I have relied on my education to help with medical and surgical treatment for my extended family. I am very thankful for the help that was given to us at so many points. There is a significant story that stood out for our family. It is a personal one for me. One of my best friends went on to become a pediatric otolaryngologist. Our third daughter was born with a very complicated ear, nose, and throat problem. He, among many other talented people, saved her life. The whole tertiary team has been dedicated to her and our family from the beginning. They have helped my whole family with this journey. She will graduate from high school soon. Where would I be without him, and them? He also doesn't accept much attention for all that he, the department, and the hospital did for my wife, family, and me. I am thankful for these humble, dutiful, and wonderful people.





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Academy and Foundation Cluster and Committee Rosters

The following are the committee rosters of the Academy and Foundation, grouped by clusters. These are all members, unless otherwise noted, who were appointed to terms October 1, 2013, as well as continuing their service. The number following each name indicates end of their term.

If you'd like to serve on a committee, applications are now being accepted through February 3, 2014. Please submit your application at www.entnet.org/committees/

Review the committee rosters online for the most up-to-date listing at www.entnet.org/Community/committeeRoster.cfm

Images depict members at committee activities from this year's annual meeting by julesclifford.com.

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The Triological Society continues to promote research into the causes of and treatments for otolaryngic diseases by providing financial support for the research efforts of young otolaryngologists. Since 1974, the Society has awarded more than \$3 million to otolaryngologists-head and neck surgeons in support of clinical and basic research. The Society's two competitive research grant programs are described here.

Triological Society Research Career Development Awards

Research Career Development Awards are available to otolaryngologists who hold full-time, part-time and contributed service medical school faculty appointments. These awards provide support for the research career development of otolaryngologists-head and neck surgeons who have made a commitment to focus their research endeavors on patient-oriented research such as clinical trials, translational research, outcomes research and health services research. Five awards are available for up to \$40,000 each to be expended over a one or two year period.

Letters of intent are due December 16, 2013 (midnight ET) and applications are due January 15, 2014 (midnight ET) through the CORE grant program.

Guidelines and additional information are available at http://www.triological.org/researchgrants.htm. Questions may be referred to Gail Binderup at info@triological.org or 402-346-5500.

Triological Society/American College of Surgeons Clinical Scientist Development Award

This award provides supplemental funding to otolaryngologists-head and neck surgeons who receive a new NIH Mentored Clinical Scientist Development Award (K08/K23) in 2013/2014 or have an existing award with a minimum of 3 years remaining in the funding period as of June 1, 2014. This award is being offered as a means to facilitate the research career development of otolaryngologists-head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal prior to the conclusion of the K award. This award will provide financial support in the amount of \$80,000 per year for up to five years, or for the remainder of the term of existing grants, to supplement the K08/K23 award. Funding is dependent upon receipt of meritorious applications.

The application deadline is May 10, 2014.

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The Human Cost of Healthcare

Stephanie Ashmore Senior Research Officer British Medical Association, London, UK

Mahmood F. Bhutta, FRCS, DPhil ENT Surgery Registrar, John Radcliffe Hospital, Oxford, UK Founder, Medical Fair and Ethical Trade Group, British Medical Association

Editor's Note: During the 2012 Cochrane Colloquium in New Zealand, several Academy members and staff had the good fortune to be introduced to Mahmood Bhutta, FRCS, DPhil, research fellow, Oxford University, and founder of the British Medical Association's Medical Fair and Ethical Trade Group. Upon hearing of this compelling global health-related concern, they invited Dr. Bhutta and his senior research officer, Stephanie Ashmore, to submit an article for the Bulletin. While the Academy has not conducted research itself on the issue of unethical working conditions in the manufacture of some medical products, we are pleased to share this information with you for your consideration.

Introduction

Every year, trillions of dollars are spent on medical supplies. In many cases, little consideration is given to the conditions in which they are made and their impact on the people who make them. Research carried out by the British Medical Association (BMA) Medical Fair and Ethical Trade Group has revealed unethical working conditions in the manufacture of a number of medical products, especially those bound for the operating room.^{1,2,3,4} The operating room is the largest user of medical supplies within the hospital, typically accounting for a third of all hospital supply costs.⁵

When making purchasing decisions for healthcare, consideration is given to value for money and quality, but consideration is rarely given to the conditions in which these supplies are made. Abuses of labor standards have been uncovered in the manufacture of many of the highthroughput supplies used routinely in the operating room, including latex gloves from Malaysia,¹ surgical masks from Mexico,² cotton scrubs from South Asia,³ and surgical instruments from Pakistan.⁴ Awareness of campaigns for fair and ethical trade of consumer products such as coffee, chocolate, and clothing is high, but the same scrutiny is not applied to commodities used every day in medicine.

Surgical Instruments

A well-documented example is the surgical instrument industry, which is a major focus of the BMA's ethical trade campaign. The vast majority of surgical instruments are made either in Tuttlingen in Germany or Sialkot in Pakistan. Exports of surgical instruments from Pakistan alone are worth \$300 million per year and up to 30 percent are exported to the United States,⁶ usually supplied a healthcare provider for about \$80; the Pakistani manufacturer would receive about \$1.50.

Manufacture of surgical instruments is an intensive multistage process involving forging, annealing, filing, grinding, drilling, riveting, de-scaling, and polishing. Workers face risks to their health including injury from heavy machinery, repetitive strain injuries, exposure to poor electrical wiring, metal dust, and noise, as well as toxic chemicals, including sulfuric acid, nitric acid, and trichloroethylene.3,4,8,9 An estimated 5,800 children work full time, six days a week, in the surgical instrument industry, some as young as seven. Children are often employed in high-risk, labor-intensive tasks such as grinding and polishing.8,10

Ethical trade relies on transparency, open dialogue, and continual improvement. As such, there is no "ethical trade" label.

through local suppliers as Pakistani companies have difficulty accessing healthcare markets directly.

Outsourcing the manufacture of surgical instruments to developing countries can help boost income in local economies and support development, but outsourcing often involves seeking the lowest price, risking exploitation of workers and abuse of labor rights.

There are an estimated 50,000 manual laborers working in the surgical instrument industry in Sialkot. A typical laborer will work 12 hours a day, seven days a week and earn about \$2 per day, less than the living wage set by the Pakistan government.⁷ Conditions in the major factories tend to be good, but due to competition and consumer demand for low-cost products, much of the work is outsourced to backstreet garages, undermining labor standards. A finished surgical instrument might be bought by

Other Manufacturing Regions

Mexico is also a major manufacturer of medical products, exporting \$9 billion of low-tech medical products such as surgical masks and bandages to the U.S. every year. The global financial crisis has led to cuts in wages and labor standards as companies try to lower costs and remain competitive. Many workers have been moved from factories to home-based working, where they are not paid regular wages or entitled to benefits. Neither working conditions nor the identity of workers is checked, which risks the use of child labor.²

Problems have also been found in Malaysia, the world's largest manufacturer of medical gloves. A large Malaysian glove factory employed workers for excessive hours and workers were subject to physical and sexual harassment. Healthcare clothing made in India also has been found to have been made under conditions of excessive working hours.

U.S. Purchasing and Policy

Supply chains for medical products are often complex. Most of the supplies used in the operating room are probably purchased by the hospital though a Group Purchasing Organization (GPO), which negotiates contracts with suppliers. In the U.S., the healthcare industry spends more than \$200 billion annually on medical and non-medical products, with more than 70 percent spent via a GPO.¹¹ At present, the U.S. has no universal policy for ensuring basic labor standards in the manufacture of medical products.

The problem with surgical instrument manufacturing has nonetheless been recognized in the U.S. for nearly three decades. Surgical instrument manufacture is listed in the U.S. Department of Labor's List of Goods Produced by Child Labor or Forced Labor¹² and U.S. government policy states that "companies and industry groups should implement social compliance systems to ensure they are not directly or indirectly causing or contributing to labor abuses in their supply chains." More recently, the U.S. Department of Labor Bureau of International Labor Affairs has created "a standard set of practices" and an online "toolkit" to support the establishment of strong social compliance systems for businesses at http://www. dol.gov/ilab/child-forced-labor/index. htm.13 The policy suggests auditing and monitoring of suppliers, and preventing suppliers using child labor from entering U.S. markets.

Although these ideas appear laudable, experience has shown that policies involving audit and boycotting are ineffective and may even be harmful. A culture of audit leads to an antagonistic relationship between manufacturer and purchaser. The majority of factories subject to audit will keep double books and will coach workers ahead of audits.¹⁴

Elimination of child labor cannot be achieved without understanding why it exists, identifying alternative education or employment opportunities for children, and realizing the potential economic impact of removing a



Teenagers welding laryngoscope blades in Sialkot, Pakistan.

working member of a family. A simple boycott can make working conditions for children worse. In surgical instrument manufacture in Pakistan, many U.S. and international suppliers have stipulated conditions including a ban on child labor, and the International Labor Organization (ILO) ran a program that aimed to eliminate child labor in the industry.^{15,16} However, despite decades of work, such policies and programs have failed to significantly affect child labor in surgical instrument manufacture.

Ethical Trade and Fair Trade

Modern approaches to addressing labor rights abuses focus on models of "ethical trade" or "fair trade." Both models aim to make international trade work better for poor and otherwise disadvantaged people, through different but complementary approaches.

Fair trade is a bottom-up approach that aims to certify products (especially agricultural products) that are made with assured labor standards and includes a premium paid to workers for social causes. The approach relies on labeling of products and so is consumer led, with huge growth in the U.S. in recent years.¹⁷ The approach could be used in some parts of the medical sector by certifying the raw cotton used to make healthcare bandages, gauze, or uniforms, or for latex for manufacturing gloves or catheters.

Ethical trade is a top-down approach, and refers to the steps that purchasing organizations, such as hospitals or GPOs, take to improve the pay and conditions of people involved in the supply of goods and services. It asks purchasers to systematically assess the risk of labor rights abuses in the goods and services they procure, and to push for improvement where necessary. This includes working with companies throughout the supply chain to help workers realize fundamental rights, such as the right to safe and decent working conditions, to be paid at least the legal minimum wage, to join and form unions so they can bargain collectively for their rights, and to eliminate child labor. Ethical trade relies on transparency, open dialogue, and continual improvement. As such, there is no "ethical trade" label. Evidence suggests that this approach also makes business and financial sense: improving labor standards leads to improved productivity, better quality, and better worker retention through improved morale.18,19 Consequently, ethically manufactured products do not need to cost more and, in many cases, actually cost less to manufacture.

Campaign for Ethical Trade in the Healthcare Sector

The BMA has been campaigning for ethical purchasing in healthcare since 2007. This has led to UK government support for ethical procurement in the public sector²⁰ and the publication of guidance and training resources for procurement staff.^{21,22}

Procurement professionals in the UK now have the tools to develop an ethical purchasing strategy, map and risk assess their supply chains, seek commitment to continuous improvement from suppliers, and to specify ethical criteria when making purchasing decisions. Similar policies are in place in other European countries, including Sweden, Norway, and Denmark. These resources are relevant to all healthcare procurement systems and accessible anywhere in the world.

Doctors in the UK have shown strong support for the campaign, with research showing that 88 percent support the BMA campaign for National Health Service organizations to adopt ethical procurement policies.²³

What can clinicians do to influence procurement in the health sector in the U.S.?

As end-users of medical commodities, healthcare professionals can be powerful advocates by campaigning for change in the way healthcare providers purchase supplies. A number of advocacy tools have been developed, including a short film "The Human Cost of Healthcare."²⁴

Healthcare professionals can support the campaign by raising awareness among colleagues or setting up a multistakeholder team with representatives from across healthcare organizations. Involving individuals from across the organization is important-for example, the corporate social responsibility lead, chief executive, public relations manager, and procurement manager, as well as clinicians. Most healthcare providers in the U.S. make purchasing decisions in a committee. Find out who is on this committee and tell them about ethical procurement. Once senior-level support is secured, the committee could raise these issues with their GPO.

The healthcare sector, with its huge purchasing power, can improve conditions for workers around the world. The more individuals and organizations raise these issues with suppliers, the more companies will change procurement practices and drive ethical improvements in supply chains. By supporting this campaign, healthcare professionals can improve not just patients' lives but those of workers risking their health to make products for the health sector—whether children making surgical instruments in Pakistan, women sewing nurses' uniforms in India, or home workers producing surgical masks in Mexico.

Find out how you can get involved; visit www.fairmedtrade.org.uk.

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Academy Advantage Partner: Search Engine Optimization (SEO) at a Glance

By Glenn Lombardi

f you want to bring new patients to your practice, you need to be where they look. The Yellow Pages are long dead, and while direct mail and other old methods can sometimes work, Google is far and away the most proactive way to make your practice visible online. The facts speak for themselves.

SearchEngineJournal and Google "Keyword Planner" reports:

- Search is one of the top two activities performed on the Internet, second only to email.
- It's also the No. 1 driver of traffic to content sites, beating social media by more than 300 percent.
- 90 percent of online experiences start with a search engine.
- 16.6 million people search for "ENT" online every month.

And so the bottom line is obvious: to keep your practice growing, you need to understand how search engine optimization (SEO) works, and how to use it effectively as part of your web presence. Otherwise, you might not appear on search engines at all.

The Most Common Search Categories: Examples and Advice

Location-Based Search: "ENT, Chicago, IL."

The front page of results is the holy grail of Internet visibility—75 percent of search users never look further.



And unless you're the only ENT in Chicago, you won't show up there. So if you practice in a metropolitan area, it's best to use SEO to improve your search ranking for specific neighborhoods. Try optimizing for searches such as "ENT, Wicker Park" instead of going for the whole metropolitan area.

General Search: "Hearing Aid Evaluations, Boston"

One of the best ways to get your practice to stand out is to optimize your website for specific services rather than the catchall of "ENT." If you specialize in a certain procedure or want to drive more attention to your less popular services, optimizing for general, service-based queries is a good way to differentiate your practice from the competition.

Search After Referral: "Mark Rosewater, ENT, Seattle"

Patients who have already received a referral to you often search this way. So if your name is part of what drives patients to your practice, then optimizing accordingly is always a good idea. It's also crucial to pay attention to your reviews on sites such as Yelp and Healthgrades[®], because those reviews will appear alongside your website.

SEO is an ever-changing field, so give yourself a quick checkup today. If you don't know how, call an expert like the ones at Officite, and put your practice in the spotlight.

Officite Practice Website Leader

About the Author: Glenn Lombardi is president of Officite, the national leader in websites and online marketing strategies for healthcare professionals. Officite is a partner of the AAO-HNS' Academy Advantage program and has built more than 20,000 websites and generated more than 600,000 new patient appointments. They specialize in helping practices graduate from a simple website to a full web presence platform, offering solutions such as turnkey social media strategies, expert search marketing, top-tier patient education, continual reputation monitoring, and premium mobile websites. For more information, visit www. officite.com or call 877-889-4042.

Farewell and Thanks to Gregory W. Randolph, MD, AAO-HNSF Coordinator for International Affairs, 2009-2013

fter serving a four-year term as International Coordinator, **Gregory W. Randolph, MD**, is stepping down to be succeeded by James E. Saunders, MD, former chair, Humanitarian Efforts Committee and 2013 awardee of the Humanitarian Award. Our thanks go to Dr. Randolph for his tireless efforts to build up and promote the Academy's international program among Academy members with international contacts.

Dr. Randolph transformed the International Steering Committee into a high-performing operational committee by appointing outstanding Academy leaders as Regional Advisors, who act as liaisons to the International Corresponding Societies in their regions. Several past presidents are among the Regional Advisors: **G. Richard Holt, MD, D-BE, MSE, MPH** (Middle East), **David W. Kennedy, MD** (Europe), **K.J. Lee, MD** (Pacific Rim), **Eugene** **N. Myers, MD, FRCSEd** (Hon.) (the Balkans, Greece, and Turkey), and **James L. Netterville, MD** (Africa).

On Dr. Randolph's watch, International Fellows and Members of the Academy are now number 1,200 from 93 countries and the International Corresponding Societies (ICS) network has grown to 54 societies on six continents. New corresponding societies include those of El Salvador, Honduras, Kenya, Nicaragua, Paraguay, South Africa, and the College of Surgeons of East, Central and Southern Africa (COSECSA.)

Dr. Randolph is among those who generously supported the International Visiting Scholars. Since 2008, 37 scholars from 18 countries have attended our annual meetings and take part in observerships.

To show the extent of the Academy's involvement in advancing the specialty around the globe, Dr. Randolph launched the first Global Health 2010: Your Academy around the World at the Annual Meeting & OTO EXPO in Boston, MA, with eight "Goodwill Ambassadors" from Australia, Germany, Haiti, New Zealand, Serbia, UAE, Venezuela, and Zimbabwe, introduced by their Regional Advisors. Since then the Global Health event has taken place annually with speakers from 30 countries.

Dr. Randolph will continue to be active in international organizations. He worked closely with Professor Chong-Sun Kim and his organizing committee on the recent World Congress of the International Federation of Oto-Rhino-Laryngology Societies (IFOS) in Seoul, Korea, June 2013, and is now on the IFOS Executive Board and the Otolaryngology Education Committee, planning for the 2017 World Congress in Paris.

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Clinical Practice Guideline Summary: Bell's Palsy

Reginald Baugh, MD; Gregory Basura, MD, PhD; Lisa Ishii, MD, MHS; Seth R. Schwartz, MD, MPH; Caitlin Murray Drumheller; Rebecca Burkholder, JD; Nathan A. Deckard, MD; Cindy Dawson, MSN, RN, CORLN; Colin Driscoll, MD; M. Boyd Gillespie, MD, MSc; Richard K. Gurgel, MD; John Halperin, MD, FAAN; Ayesha N. Khalid, MD; Kaparaboyna Ashok Kumar, MD, FRCS, FAAFP; Alan Micco, MD; Debra Munsell, DHSc, PA-C, DFAAPA; Steven Rosenbaum, MD, FAAEM; William Vaughan

his month, the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) published its latest clinical practice guideline, Bell's Palsy, as a supplement to *Otolaryngology—Head and Neck Surgery*. Recommendations developed encourage accurate and efficient diagnosis and treatment and, when applicable, facilitating patient follow-up to address the management of long-term sequelae, or evaluation of new or worsening symptoms not indicative of Bell's palsy. The guideline was developed using the *a priori* protocol outlined in the *AAO-HNS Clinical Practice Guideline Development Manual.*¹ The complete guideline is available at http://oto. sagepub.com.

To assist in implementing the guideline recommendations, this article summarizes the rationale, purpose, and key action statements. Recommendations in a guideline can be implemented only if they are clear and identifiable. This goal is best achieved by structuring the guideline around a series of key action statements, which are supported by amplifying text and action statement profiles. For ease of reference only the statements and profiles are included in this brief summary. Please refer to the complete guideline for the important information in the amplifying text that further explains the supporting evidence and details of implementation for each key action statement.

For more information about the AAO-HNSF's other quality knowledge products (clinical practice guidelines and clinical consensus statements), our guideline development methodology, or to submit a topic for future guideline development, please visit http://www.entnet.org/guidelines.

Introduction

Bell's palsy, named after the Scottish anatomist, Sir Charles Bell, is the most common acute mononeuropathy, or disorder affecting a single nerve, and is the most common diagnosis associated with facial nerve weakness/paralysis.1 Bell's palsy is a rapid unilateral facial nerve paresis (weakness) or paralysis (complete loss of movement) of unknown cause. The condition leads to the partial or complete inability to voluntarily move facial muscles on the affected side of the face. Although typically self-limited, the facial paresis/ paralysis that occurs in Bell's palsy may cause significant temporary oral incompetence and an inability to close the eyelid, leading to potential eye injury. Additional long-term poor outcomes do occur and can be devastating to the patient. Treatments are generally designed to improve facial function and facilitate recovery.

The myriad treatment options for Bell's palsy include medical therapy (steroids and antivirals, alone and in combination),²⁻⁴ surgical decompression,⁵⁻⁸ and complementary and alternative therapies such as acupuncture. Some controversy exists regarding



Doctor, Please Explain **Bell's Palsy**



including:

How is it treated?What if I don't fully recover?



Bell's Palsy Guideline

Ine AAO-HNSF'S latest guideline is now available at www.otojournal.org and on www.entnet.org

the effectiveness of several of these options and there are consequent variations in care. Additionally, there are numerous diagnostic tests available that are used in the evaluation of Bell's palsy patients. Many of these tests are of questionable benefit in Bell's palsy, including laboratory testing,9,10 diagnostic imaging studies, and electrodiagnostic tests.¹⁰⁻¹² Furthermore, while Bell's palsy patients enter the healthcare system with facial paresis/paralysis as a primary complaint, not all patients with facial paresis/paralysis have Bell's palsy. It is a concern that patients with alternative underlying etiologies may be misdiagnosed or have unnecessary delay in diagnosis. All of these quality concerns provide an important opportunity for improvement in the diagnosis and management of patients with Bell's palsy.

When evaluating a patient with facial weakness/paralysis for Bell's palsy, the following should be considered:

- Bell's palsy is rapid in onset (<72 hours).</p>
- Bell's palsy is diagnosed when no other medical etiology is identified as a cause of the facial weakness.
- Bilateral Bell's palsy is rare.^{13,14}

- Currently, no cause for Bell's palsy has been identified.
- Other conditions may cause facial paralysis, including stroke, brain tumors, tumors of the parotid gland or infratemporal fossa, cancer involving the facial nerve, and systemic and infectious diseases including zoster, sarcoidosis, and Lyme disease.^{1,15-17}
- Bell's palsy is typically self-limited.
- Bell's palsy may occur in men, women, and children, but is more common in those 15-45 years old; those with diabetes, upper respiratory ailments, or compromised immune systems; or during pregnancy.^{16,18}

The guideline development group (GDG) recognizes that Bell's palsy is a diagnosis of exclusion requiring the careful elimination of other causes of facial paresis or paralysis. Although the literature is silent on the precise definition of what constitutes acute onset in facial paralysis, the GDG accepted the definition of "acute" or "rapid onset" to mean that the occurrence of paresis/paralysis typically progresses to its maximum severity within 72 hours of onset of the paresis/paralysis. This guideline does not focus on facial paresis/paralysis due to neoplasms, trauma, congenital or syndromic problems, specific infectious agents, or post-surgical facial paresis or paralysis; nor does it address recurrent facial paresis/paralysis. For the purposes of this guideline, Bell's palsy is defined as: Acute unilateral facial nerve paresis or paralysis with onset in less than 72 hours and without an identifiable cause.

Literature cited throughout this guideline often uses the House-Brackmann facial nerve grading scale. This is a commonly used scale designed to systematically quantify facial nerve functional recovery after surgery that puts the facial nerve at risk, but has been used to assess recovery after trauma to the facial nerve, or Bell's palsy.¹⁹ It was not designed to assess initial facial nerve paresis or paralysis of Bell's palsy. The House-Brackmann facial nerve grading system is described in **Table 1**.

While a viral etiology is suspected, the exact mechanism of Bell's palsy is currently unknown.²¹ Facial paresis or paralysis is thought to result from facial nerve inflammation and edema. As the facial nerve travels in a narrow canal within the temporal bone, swelling may lead to nerve compression and result in temporary or

Table 1. House-Brackmann Facial Nerve Grading System ²⁰			
Grade		Defined by	
1	Normal	Normal facial function in all areas.	
2	Mild dysfunction	Slight weakness noticeable only on close inspection. At rest: normal symmetry of forehead, ability to close eye with minimal effort and slight asymmetry, ability to move corners of mouth with maximal effort and slight asymmetry. No synkinesis, contracture, or hemifacial spasm.	
3	Moderate dysfunction	Obvious, but not disfiguring difference between two sides, no functional impairment; noticeable, but not severe synkinesis, contracture, and/or hemifacial spasm. At rest: normal symmetry and tone. Motion: slight to no movement of forehead, ability to close eye with maximal effort and obvious asymmetry, ability to move corners of mouth with maximal effort and obvious asymmetry. Patients who have obvious, but no disfiguring synkinesis, contracture, and/or hemifacial spasm are grade III regardless of degree of motor activity.	
4	Moderately severe dysfunction	Obvious weakness and/or disfiguring asymmetry. At rest: normal symmetry and tone. Motion: no movement of forehead; inability to close eye completely with maximal effort. Patients with synki- nesis, mass action, and/or hemifacial spasm severe enough to interfere with function are grade IV regardless of motor activity.	
5	Severe dysfunction	Only barely perceptible motion. At rest: possible asymmetry with droop of corner of mouth and decreased or absence of nasal labial fold. Motion: no movement of forehead, incomplete closure of eye and only slight movement of lid with maximal effort, slight movement of corner of mouth. Synkinesis, contracture, and hemifacial spasm usually absent.	
6	Total paralysis	Loss of tone; asymmetry; no motion; no synkinesis, contracture, or hemifacial spasm.	

permanent nerve damage. The facial nerve carries nerve impulses to muscles of the face, and also to the lacrimal glands, salivary glands, stapedius muscle, taste fibers from the anterior tongue, and general sensory fibers from the tympanic membrane. Accordingly, patients with Bell's palsy may experience dryness of the eye or mouth, taste disturbance or loss, hyperacusis, and sagging of the eyelid or corner of the mouth.^{13,18} Ipsilateral pain around the ear or face is not an infrequent presenting symptom.^{21,22}

Numerous diagnostic tests have been used to evaluate patients with acute facial paresis/paralysis for identifiable causes, or aid in predicting long-term outcomes. Many of these tests were considered in the development of this guideline, including:

 Imaging—Computed tomography (CT) or magnetic resonance imaging (MRI)—to identify potential infection, tumor, fractures, or other potential causes for facial nerve involvement;

- Electrodiagnostic testing to stimulate the facial nerve to assess the level of facial nerve insult;
- Serologic studies to test for infectious causes;
- Hearing testing to determine if the cochlear nerve or inner ear has been affected;
- Vestibular testing to determine if the vestibular nerve is involved; and
- Schirmer's tear testing to measure the eye's ability to produce tears.

Most patients with Bell's palsy show some recovery without intervention within two to three weeks after onset of symptoms, and completely recover within three to four months.¹ Moreover, even without treatment, facial function is completely restored in nearly 70 percent of Bell's palsy patients with complete paralysis within six months, and as high as 94 percent of patients with incomplete paralysis; accordingly, as many as 30 percent of patients do not recover completely.^{23,24} Given the dramatic effect of facial paralysis on patient appearance, quality of life, and psychological well-being, treatment is often initiated in an attempt to decrease the likelihood of incomplete recovery. Corticosteroids and antiviral medications are the most commonly used medical therapies. New trials have explored the benefit of these medications. The benefit of surgical decompression of the facial nerve remains relatively controversial.^{23,25}

There are both short- and long-term sequelae of Bell's palsy, including an inability to close the eye, drying and corneal ulceration of the eye, and vision loss. These can be prevented with appropriate eye care. The short-term sequelae, such as inability to close the eye and drying of the eye warrant careful management, but treatment results can be favorable. Long-term, the disfigurement of the face due to incomplete recovery of the facial nerve can have devastating effects on psychological well-being and

quality of life. With diminished facial movement and marked facial asymmetry, patients with facial paralysis can have impaired interpersonal relationships and may experience profound social distress, depression, and social alienation.26 There are a number of rehabilitative procedures to normalize facial appearance, including eyelid weights or springs, muscle transfers and nerve substitutions, static and dynamic facial slings, and botulinum toxin injections to eliminate facial spasm/synkinesis.27-31 This guideline will, however, focus more on the acute management of Bell's palsy and will not address these interventions in detail.

Purpose

The primary purpose of this guideline is to improve the accuracy of diagnosis for Bell's palsy, to improve the quality of care and outcomes for Bell's palsy patients, and to decrease harmful variations in the evaluation and management of Bell's palsy. This guideline addresses these needs by encouraging accurate and efficient diagnosis and treatment and, when applicable, facilitating patient follow-up to address the management of long-term sequelae, or evaluation of new or worsening symptoms not indicative of Bell's palsy. The guideline is intended for all clinicians in any setting who are likely to diagnose and manage patients with

to limit treatment or care provided to individual patients. The guideline is not intended to replace clinical judgment for individualized patient care. Our goal is to create a multidisciplinary guideline with a specific set of focused recommendations based upon an established and transparent process that considers levels of evidence, harm-benefit balance, and expert consensus to resolve gaps in evidence. These specific recommendations are designed to improve quality of care and may be used to develop performance measures.

Key Action Statements

STATEMENT 1. PATIENT HISTORY AND PHYSICAL EXAMINATION:

Clinicians should assess the patient using history and physical examination to exclude identifiable causes of facial paresis or paralysis in patients presenting with acute onset unilateral facial paresis or paralysis. <u>Strong recommenda-</u> tion based on observational studies of alternative causes of facial paralysis and reasoning from first principles, with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate Evidence Quality: Grade C
- Level of confidence in evidence: High
- Benefit: Identification of other causes of facial paresis/paralysis, enabling

accurate diagnosis; avoidance of unnecessary testing and treatment; identification of patients for whom other testing or treatment is indicated; opportunity for appropriate patient counseling

- Risks, harms, costs: None
- Benefit-Harm Assessment: Preponderance of benefit
- Value judgments: The GDG felt that assessment of patients cannot be performed without a history and physical examination, and that it would not be possible to find stronger evidence, as studies excluding these steps cannot ethically be performed. Other causes of facial paresis/paralysis may go unidentified; a thorough history and physical examination will help avoid missed diagnoses or diagnostic delay.
- Intentional vagueness: None
- Role of patient preferences: None
- Exceptions: None
- Policy level: Strong recommendation
 - Differences of opinion: None

STATEMENT 2. LABORATORY TESTING:

Clinicians should not obtain routine laboratory testing in patients with new onset Bell's palsy. <u>Recommendation</u> (<u>against</u>) based on observational studies and expert opinion with a preponderance of benefit over harm.

Bell's palsy. The target population is inclusive of both adults and children presenting with Bell's palsy.

This guideline is intended to focus on a limited number of quality improvement opportunities deemed most important by the GDG, and is not intended to be a comprehensive guide for diagnosing and managing Bell's palsy. The recommendations outlined in this guideline are not intended to represent the standard of care for patient management, nor are the recommendations intended

Table 2. Abbreviations and Definitions of Common Terms

Term	Definition
Acute	Occurring in less than 72 hours
Bell's palsy	Acute unilateral facial nerve paresis or paralysis with onset in less than 72 hours and without identifiable cause
Electromyography (EMG) testing	A test in which a needle electrode is inserted into affected muscles to record both spontaneous depolarizations and the responses to volun- tary muscle contraction
Electroneuronography (ENoG) testing (neurophysiologic studies)	A test used to examine the integrity of the facial nerve, in which surface electrodes record the electrical depolarization of facial muscles following electrical stimulation of the facial nerve
Facial paralysis	Complete inability to move the face
Facial paresis	Incomplete ability to move the face
Idiopathic	Without identifiable cause

Action Statement Profile

- Aggregate evidence quality: Grade C
- Level of confidence in evidence: High
- Benefit: Avoidance of unnecessary testing and/or treatment, avoidance of pursuing false positives, cost savings
- Risks, harms, costs: Potential missed diagnosis
- Benefit-harm assessment: Preponderance of benefit
- Value judgments: While the GDG felt that there are circumstances where specific testing is indicated in at-risk patients (such as Lyme disease serology in endemic areas) these patients can usually be identified by history.
- Intentional vagueness: We used the word "routine" to specify that under certain circumstances, laboratory testing may be indicated.
- Role of patient preferences: Small (there is an opportunity for patient education)
- Exceptions: None
- Policy level: Recommendation (against)
- Differences of opinion: None

STATEMENT 3. DIAGNOSTIC IMAGING:

Clinicians should not routinely perform diagnostic imaging for patients with new onset Bell's palsy. Recommendation (against) based on observational studies with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade C
- Level of confidence in evidence: High
- Benefit: Avoidance of unnecessary radiation exposure, avoidance of incidental findings, avoidance of contrast reactions, cost savings
- Risks, harms, costs: Risk of missing other cause of facial paresis/paralysis
- Benefit-harm assessment: Preponderance of benefit
- Value judgments: None
- Intentional vagueness: The word "routine" was used to indicate there may be some clinical findings that would warrant imaging
- Role of patient preferences: Small, however there is an opportunity for patient education/counseling
- Exceptions: None

- Policy level: Recommendation (against)
- Differences of opinion: None

STATEMENT 4. ORAL STEROIDS:

Clinicians should prescribe oral steroids within 72 hours of symptom onset for Bell's palsy patients 16 years and older. <u>Strong recommendation</u> based on high-quality randomized controlled trials with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade A
- Level of confidence in evidence: High ■ Benefit: Improvement in facial nerve
- function, faster recovery
- Risks, harms, costs: Steroid side effects, cost of therapy
- Benefit-harm assessment: Preponderance of benefit
- Value judgments: None
- Intentional vagueness: None
- Role of patient preferences: Small
- Exceptions: Diabetes, morbid obesity, previous steroid intolerance, and psychiatric disorders. Pregnant women should be treated on an individualized hasis
- Policy level: Strong recommendation
- Differences of opinion: None

STATEMENT 5A. ANTIVIRAL MONOTHERAPY:

Clinicians should not prescribe oral antiviral therapy alone for patients with new onset Bell's palsy. Strong recommendation (against) based on highquality randomized controlled trials with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade A
- Level of confidence in evidence: High Benefit: Avoidance of medication side effects, cost savings
- Risks, harms, costs: None
- Benefit-harm assessment: Preponderance of benefit
- Value judgments: None
- Intentional vagueness: None

Differences of opinion: None

- Role of patient preferences: Small
- Exceptions: None
- Policy level: Strong recommendation (against)

Action Statement Profile

■ Aggregate evidence quality: Grade B

STATEMENT 5B. COMBINATION

therapy in addition to oral steroids

on randomized controlled trials with

within 72 hours of symptom onset for

patients with Bell's palsy. Option based

minor limitations and observational stud-

ies with equilibrium of benefit and harm.

Clinicians may offer oral antiviral

ANTIVIRAL THERAPY:

- Level of confidence in evidence: Medium, because the studies cannot exclude a small effect
- Benefit: Small potential improvement in facial nerve function
- Risks, harms, costs: Treatment side effects, cost of treatment
- Benefit-harm assessment: Equilibrium of benefit and harm
- Value judgments: Although the data were weak, the risks of combination therapy were small
- Intentional vagueness: None
- Role of patient preferences: Large; significant role for shared decision making
- Exceptions: Diabetes, morbid obesity, and previous steroid intolerance. Pregnant women should be treated on an individualized basis.
- Policy level: Option
- Differences of opinion: None

STATEMENT 6. EYE CARE:

Clinicians should implement eye protection for Bell's palsy patients with impaired eye closure. Strong recommendation based on expert opinion and a strong clinical rationale with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade X
- Level of confidence in evidence: High. Eye protection has been the standard of care, and comparative studies with a no treatment arm are unethical.
- Benefit: Prevention of eye complications
- Risks, harms, costs: Cost of eye protection implementation, potential side effects of eye medication





- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: None
- Intentional vagueness: None
- Role of patient preferences: Small
- Exceptions: None
- Policy level: Strong recommendation
- Differences of opinion: None

STATEMENT 7A. ELECTRODIAGNOSTIC TESTING WITH INCOMPLETE PARALYSIS:

Clinicians should not perform electrodiagnostic testing in Bell's palsy patients with incomplete facial paralysis. <u>Recommendation (against)</u> based on observational studies with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade C
- Level of confidence in evidence: High
- Benefit: Avoidance of unnecessary testing, cost savings
- Risks, harms costs: None
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: None
- Intentional vagueness: None
- Role of patient preferences: None
- Exceptions: None
- Policy Level: Recommendation (against)
- Differences of opinion: None

STATEMENT 7B. ELECTRODIAGNOSTIC TESTING WITH COMPLETE PARALYSIS:

Clinicians may offer electrodiagnostic testing to Bell's palsy patients with complete facial paralysis. <u>Option</u> based on observational trials with equilibrium of benefit and harm.

Action Statement Profile

- Aggregate evidence quality: Grade C
- Level of confidence in evidence: Medium due to variations in patient selection, study design, and heterogeneous results
- Benefit: Provide prognostic information for the clinician and patient, identification of potential surgical candidates
- Risks, harms, costs: Patient discomfort, cost of testing
- Benefit-harm assessment: Equilibrium of benefit and harm

- Value judgments: None
- Intentional vagueness: None
- Role of patient preferences: Large role for shared decision making, as electrodiagnostic testing may provide only prognostic information for the patient
- Exceptions: None
- Policy level: Option
- Differences of opinion: None

STATEMENT 8. SURGICAL DECOMPRESSION:

No recommendation can be made regarding surgical decompression for Bell's palsy patients. <u>No recommendation</u> based on low-quality, non-randomized trials and equilibrium of benefit and harm.

Action Statement Profile

- Aggregate evidence quality: Grade D
- Level of confidence in evidence: Low due to insufficient number of patients and poor quality of studies. Low confidence in the evidence led to a downgrade of the aggregate evidence quality from C to D.
- Benefit: Improved facial nerve functional recovery
- Risks, harms, costs: Surgical risks and complications, anesthetic risks, direct and indirect costs of surgery
- Benefit-harm assessment: Equilibrium of benefit and harm
- Value judgments: Although the data supporting surgical decompression are not strong, there may be a significant benefit for a small subset of patients who meet eligibility criteria and desire surgical management
- Intentional vagueness: None
- Role of patient preferences: Large. The psychological impact of facial paralysis is significant but varies among patients. Concern about the facial deformity may make some patients willing to pursue a major operation for a small increase in the chance of complete recovery while others may be more willing to accept the chance of poorer outcome to avoid surgery.
- Exceptions: None
- Policy level: No recommendation
- Differences of opinion: Major. The group was divided as to whether the evidence supported no recommendation, or an option for surgery. This difference of

opinion derived from controversy regarding the strength of evidence (C level evidence vs. D level evidence.)

STATEMENT 9. ACUPUNCTURE:

No recommendation can be made regarding the effect of acupuncture in Bell's palsy patients. <u>No recommenda-</u> <u>tion</u> based on poor quality trials and an indeterminate ratio of benefit and harm.

Action Statement Profile

- Aggregate evidence quality: Grade B
- Level of confidence in evidence: Low, due to significant methodological flaws in available evidence
- Benefit: Acupuncture may provide a potential small improvement in facial nerve function and pain
- Risks, harms, costs: Cost of acupuncture therapy, time required for therapy, therapy side effects, and delay in instituting steroid therapy
- Benefit-harm assessment: Unknown
- Value judgments: Due to the poor quality of the data and the inability to determine harm to benefit ratio, the GDG could not make a recommendation.
- Intentional vagueness: None
- Role of patient preferences: Large
- Exceptions: None
- Policy level: No recommendation
- Differences of opinion: Major. The GDG was divided regarding whether to recommend against acupuncture, or to make no recommendation.

STATEMENT 10. PHYSICAL THERAPY:

No recommendation can be made regarding the effect of physical therapy in Bell's palsy patients. <u>No</u> <u>recommendation</u> based on case series and equilibrium of benefit and harm.

Action Statement Profile

- Aggregate evidence quality: Grade D
- Level of confidence in evidence: Low, due to significant flaws in existing trials
- Benefit: Potential functional and psychological benefit
- Risks, harms, costs: Cost of therapy, time required for therapy
- Benefit-harm assessment: Equilibrium of benefit and harm

- Value judgments: Patients may benefit psychologically from engaging in physical therapy exercises
- Intentional vagueness: None
- Role of patient preferences: Large role for shared decision making
- Exceptions: None
- Policy level: No recommendation
- Differences of opinion: None

STATEMENT 11. PATIENT FOLLOW-UP:

Clinicians should reassess or refer to a facial nerve specialist those Bell's palsy patients with (1) new or worsening neurologic findings at any point, (2) ocular symptoms developing at any point, or (3) incomplete facial recovery three months after initial symptom onset. <u>Recommendation</u> based on observational studies with a preponderance of benefit over harm.

Action Statement Profile

- Aggregate evidence quality: Grade C
- Level of confidence in evidence: High
- Benefit: Reevaluation for alternate diagnoses of facial paralysis, discussion of therapeutic/reconstructive options, psychological support of patient
- Risks, harms, costs: Cost of visit, time dedicated to visit
- Benefit-harm assessment: Preponderance of benefit over harm
- Value judgments: The GDG sought to address the importance of identifying alternate diagnoses in the absence of recovery, and potential assessment for rehabilitative options. The GDG recognized a lack of established time for patient follow-up; however based on the natural history of Bell's palsy, the majority of patients will show complete recovery three months after onset.
- Intentional vagueness: There are several specialties that have the expertise to reevaluate these patients; therefore the term "facial nerve specialist" is used to indicate the clinician who could most appropriately assess new or worsening symptoms in these patients.
- Role of patient preferences: Small
- Exceptions: None

- Policy level: Recommendation
- Differences of opinion: None

Disclaimer

This clinical practice guideline is provided for informational and educational purposes only. It is not intended as a sole source of guidance in managing Bell's palsy. Rather, it is designed to assist clinicians by providing an evidence-based framework for decisionmaking strategies. The guideline is not intended to replace clinical judgment or establish a protocol for all individuals with this condition, and may not provide the only appropriate approach to diagnosing and managing this program of care. As medical knowledge expands and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions, but they are not absolute. Guidelines are not mandates and do not and should not purport to be a legal standard of care.

The responsible physician, in light of all the circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The American Academy of Otolaryngology-Head and Neck Surgery Foundation (AAO-HNSF) emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care, or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results.

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Where Do We Go From Here? Attacking the Larger Problems in Safety and Quality



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few years back, there was real concern whether the patient safety and quality improvement renaissance following the Institute of Medicine's report in 1999 was real. In other words, were we moving the needle in actually reducing adverse events, near misses, and medical errors? This is a very basic, albeit profound question. Some experts had questioned if focusing tremendous attention on patient safety and quality improvement was taking limited resources away from other competing priorities.

Within the last few years there have been myriad studies actually demonstrating an improvement in outcomes and other concomitant patient safety/quality improvement metrics in varying practice settings. It is of course exciting to see the needle move and the tremendous efforts of providers, such as our Academy members, working to improve the quality of care for our patients.

How did the needle move? A trite answer is that there were so many opportunities that focusing on the low-hanging fruit was productive. Indeed, our Academy employed similar strategies when creating a prioritization matrix for patient safety and quality improvement work.

The bigger question is: What do we do now? How can we attack the larger problems and move the needle a similar magnitude? There are several large databases and quality improvement platforms, which I will refrain from naming, that are perhaps the wrong strategy (and I do not want to implicate any platform per se). Instead of macro-level snapshots of data, many of us believe that targeted, specialtyspecific initiatives will be necessary to make an impact and go after the more elusive specialty-specific issues.

For example, Atul Gawande, MD, and his research team made incredible contributions to the understanding of the role of checklists, especially for surgery. The next iterations may be specialty-specific or case-specific checklists. Indeed, I know of many specialty practices, surgery centers, and hospitals that have such specialty/ procedure-specific checklists to customize a standardized process.

The next generation of patient safety and quality improvement will undoubtedly require a tremendous amount of resources, as it will be geared toward specific groups of providers (emergency department physicians, hospitalists, psychiatrists, etc.). Furthermore, it will require a much broader group of leaders, as there will be

hundreds of competing initiatives. An example is the Hospital Engagement Networks (HEN) that many of our hospitals participate in. These networks are essentially huge collaboratives in which hospitals get together to look at aggregate macro-level data, as well as best practices, to collectively improve the care in their own hospitals and for the HEN itself.

To my knowledge, there are no specific HEN metrics that are pertinent specifically to otolaryngology-head and neck surgery. I am aware of quality improvement collaboratives that are beginning in our specialty that are slowly gaining traction and will most certainly be highlighted in this column as they mature.

Nevertheless, the future of patient safety and quality improvement could not be more exciting. The prior decade has shown that the needle has moved and the future looks promising that the needle will continue to move. As expected, there will be different strategies and techniques that will be required to move the needle in this decade, but we are on the right track and there will certainly be more involvement among our specialty and our members.

We encourage members to write us with any topic of interest, and we will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Please email the Academy at qualityimprovement@entnet.org to engage us in a patient safety and quality discussion that is pertinent to your practice.

Government Affairs Highlights from the Annual Meeting

uring the AAO-HNSF 2013 Annual Meeting & OTO EXPOSM in Vancouver, BC, Academy members visited the ENT PAC and Grassroots Booth—the Government Affairs "hub" during the meeting—to learn more regarding the Academy's federal legislative priorities, grassroots initiatives, and new/ongoing political programs. Here is a brief overview of what took place in Vancouver.

#FixtheSGR

This year, the U.S. House Energy and Commerce (E & C) and Ways and Means (W & M) committees have been diligently working on the development of legislation to repeal the flawed Sustainable Growth Rate (SGR) formula used to determined payments to physicians in the Medicare program, and replace it with a new payment system that rewards the delivery of high-quality and efficient healthcare. In late July, legislation was unanimously passed by the E & C Committee,

Follow Government Affairs on Twitter

Do you want to be one of the first to know the status of healthcare bills moving through Congress? Follow the Government Affairs Twitter account @AAOHNSGovtAffrs. By following us, you can learn more about the issues impacting the specialty, including repeal of the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Not a fan of Twitter? You can also visit http://www.entnet.org/Advocacy for updates.

setting the stage for possible passage of legislation by the end of the year. AAO-HNS members are encouraged to contact their lawmakers via an AAO-HNS "Legislative Action Alert" to urge swift passage of SGR repeal legislation. In Vancouver, the Grassroots Table provided attendees with easy access to the Action Alert and additional information about other AAO-HNS federal legislative priorities.

AAO-HNS Members Make I-GO Summer Kickoff a Success

With multiple events this summer during the August Congressional recess, the AAO-HNS In-district Grassroots Outreach (I-GO) program had a successful kickoff. As with many new programs, there were a few logistical issues to overcome, including the surprisingly limited number of events hosted by Members of Congress during the August break due to concerns about being "attacked" for their policy positions while attending public events.

However, AAO-HNS members met and overcame these challenges. Several members hosted private practice visits for their Members of Congress, providing tours of their facilities, demonstrating the tools of the trade, and introducing them to the hard-working staff that are essential to running a successful practice. Members without private practices coordinated calendars with their representatives and met locally with them at their legislators' district offices. This provided a more personal and less threatening setting for the legislators to speak with physicians on the front lines of patient care.

Regardless of the venue, these visits provided Members of Congress with a firsthand account of AAO-HNS legislative priorities, including the repeal of the Sustainable Growth Rate payment formula, truth-in-advertising initiatives, and support for Graduate Medical Education funding.

If you are interested in representing the specialty in a home district visit with your local policymakers, visit www.entnet.org/advocacy or contact govtaffairs@entnet.org.

Calling All Residents!

In Vancouver, the ENT PAC Board of Advisors and staff were excited to launch a new Resident and Fellowsin-Training PAC and Advocacy Involvement Campaign. The program, which relies on a simple point system, provides participants the opportunity to accrue points for themselves and their training program based on involvement in various AAO-HNS advocacy and political activities. For more information, email govtaffairs@entnet.org.

ENT PAC Goes "Rogue"

On Monday, September 30, all 2013, ENT PAC Investors were invited to attend the annual PAC "thank you" reception. This year's event took place at the Rogue Kitchen & Wetbar in Vancouver. The ENT PAC Board of Advisors and staff thank all 2013 PAC Investors! For more information, contact entpac@entnet.org.*

Lunch among Leaders

On Tuesday, October 1, former Member of Parliament and Leader of the Liberal Party in Canada, the Honourable Bob Rae, spoke at the ENT PAC Chairman's Club (\$1,000+ annual contribution) Luncheon. The lunch featured a roundtable discussion about healthcare delivery in the U.S. and Canada. For more information about ENT PAC Leadership Clubs, visit www.entpac.org.



U.S. Representative Paul Tonko visiting Albany ENT & Allergy Services.

What Is I-GO?

The newest AAO-HNS advocacy program, the In-district Grassroots Outreach or "I-GO" program, was launched earlier this year and extensively discussed during this year's annual meeting. The program, which encourages AAO-HNS members



ENT PAC Chair Lee Eisenberg, MD, (right) at a fundraiser for U.S. Representative Bill Pascrell (left).

to engage in in-district advocacy opportunities (e.g., meeting with a lawmaker, attending a fundraiser, participating in a townhall, etc.),

was a main tenet of the Government Affairs programming in Vancouver. The AAO-HNS Government Affairs staff and physician advocacy leaders hope the I-GO program will strengthen our advocacy "footprint" and provide AAO-HNS members with increased opportunities to develop relationships

with lawmakers locally and, when applicable, participate in the political process. For more information, contact govtaffairs@entnet.org.

Until the AAO-HNSF 2014 Annual Meeting & OTO EXPOSM in Orlando, ensure you receive the latest legislative and political news by joining our social media networks. **"Follow" us on Twitter @AAOHNSGovtAffrs, "Like" us on Facebook, and "Connect" to us**

on LinkedIn!

*Contributions to ENT PAC are not deductible as charitable contributions for federal income tax purposes. Contributions are volun-



ENT PAC, the political action committee of the AAO-HNS, financially supports federal Congressional

candidates and incumbents who advance the issues important to otolaryngology-head and neck surgery. ENT PAC is a NON-PARTISAN, ISSUE-DRIVEN entity that serves as your collective voice on Capitol Hill to increase the visibility of the specialty with key policymakers.

To learn more about ENT PAC, visit our PAC website at www.entpac.org (log in with your AAO-HNS ID and password).

tary, and all members of the American Academy of Otolaryngology— Head and Neck Surgery have the right to refuse to contribute without reprisal. Federal law prohibits ENT PAC from accepting contributions from foreign nationals. By law, if your contributions are made using a personal check or credit

On the Frontlines: State Legislative Tracking

AAO-HNS members are a key resource for tracking state legislation and helping communicate to policymakers its impact on the specialty and patients. Join the growing team of AAO-HNS state trackers by signing up at govtaffairs@ entnet.org to receive daily or weekly legislative tracking updates. If you identify legislation needing Academy action (e.g., letter, action alert, testimony), simply fill out the new online State Action Form at www.entnet.org/Advocacy.



Steven Levine, MD, (right) hosting an office visit with U.S. Representative Jim Himes (left).

card, ENT PAC may use your contribution only to support candidates in federal elections. All corporate contributions to ENT PAC will be used for educational and administrative fees of ENT PAC, and other activities permissible under federal law. Federal law requires ENT PAC to use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed \$200 in a calendar year. ENT PAC is a program of the AAO-HNS, which is exempt from federal income tax under section 501 (c) (6) of the Internal Revenue Code.

CPT for ENT: Coding 31000 with Balloon Dilation Procedures

Q: I've noticed that there are not any coding edits in place for CPT 31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium) when billed with 31295 (endoscopic balloon dilation of the maxillary sinus). Does this mean I can code separately for the work of lavage when performing this service?

same time. This unequivocally means that irrigation of the dilated sinus **INCLUDES** irrigation if performed at the same session.

The only time 31000 should be reported with 31295 is if the primary procedure is performed on one side and ONLY an irrigation is performed on the opposite, contralateral side. In this case, the procedures would be reported using RT and LT modifiers. A -59 modifier would not



A: No. The lavage is a lower-valued procedure performed at the same operative session on the same structure (maxillary sinus) and, therefore, would be included in the primary procedure code of 31295. Some additional things to consider are:

• The vignette associated with 31295 includes a statement that a catheter for irrigation may be placed at the

be used, as there is not currently a CCI edit in place for this code combination.

- 31000 is an open code [i.e., anterior rhinoscopic guided service] and 31295 is an endoscopic code.
- 31000 represents a separate procedure in which the nose is anesthetized, decongested and a needle or cannula inserted into the antrum for irrigation. It is not intended for flushing through a

patent or newly created surgical opening into the antrum.

The same logic would apply to 31002 with relevant sphenoid codes.

Q: In addition, there is a CCI edit in place of "1" for the code combinations of 31000 with 31256 (endoscopic maxillary antrostomy) and 31267 (endoscopic maxillary antrostomy with tissue removal from within the sinus), but I am able to bypass the edit using modifier 59 (distinct procedural service). Is it appropriate to append modifier 59 to 31000 in these instances?

A: No, it is not appropriate to append modifier 59 to 31000 just to get the procedure paid. You must meet the criteria for use of modifier 59 in order to use the modifier appropriately and bypass the CCI edits. The lavage is a lower-valued procedure performed at the same operative session on the same structure (maxillary sinus) and, therefore, would be included in the primary procedure codes of 31256, 31267. Some additional things to consider are:

- The only time 31000 should be reported with 31256, 31267 with a 59 modifier is if the primary procedure is performed on one side and ONLY an irrigation is performed on the opposite, contralateral side.
- 31000 is an open code [i.e., anterior rhinoscopic guided service] and 31256, 31267 are all endoscopic codes.
- 31000 represents a separate procedure in which the nose is anesthetized, decongested and a needle or cannula inserted into the antrum for irrigation. It is not intended for flushing through a patent or newly created surgical opening into the antrum.
- Overuse of the -59 modifier with certain code combinations can trigger a CMS review of the code combination that could alter our ability to bill separately for these codes in the future.
- The same logic would apply to 31002 with relevant sphenoid codes.

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Scientific (Oral & Poster)

Submission Opens: January 21, 2014 Submission Closes: February 18, 2014 Notifications Sent: Late April 2014



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CPT for ENT: How to Use Unlisted Codes

Q: When should I use an unlisted code?

A: An unlisted code should be used to report a procedure when no Category I or III CPT code exists to describe the procedure.

Q: When shouldn't I use an unlisted code?

A: When a valid CPT code exists to describe the procedure. Unlisted codes should not be utilized as an attempt to obtain increased reimbursement in cases where a CPT code exists, but the reimbursement for the existing CPT code is low.

Q: Are there steps I should take to increase the likelihood that my unlisted code will be paid?

A: Yes, best practices for using unlisted codes include, but are not limited to, the following:

- Obtain prior authorization or certification for elective cases.
- Learn what the carrier needs to process the unlisted code; many request the following: Submit your claim on a CMS 1500 claim form with an operative note and cover letter outlining how you are using the unlisted code and how you've

Othintspector

selected your "base code." Access the Academy's sample unlisted code cover letter here: http://www.entnet.org/ Practice/Appeal-Template-letters.cfm

- Select a base code that is SIMILAR to the procedure you performed. The code should represent surgery on the same area of the body and utilize a similar approach and exposure to the procedure you performed.
- In your cover letter, list two to three things that make the unlisted procedure more or less difficult than the comparator CPT code.
- List the RVUs of the similar code to be sure it reflects a fair value for the work you have performed. If it does not, select a different base code.

Use your normal fee for the comparison code. Note that the payer will then adjust this up or down from their fee schedule, not your charge.

Q: Are there any other areas to be cautious about, or to avoid?

A: Yes, keep the following in mind when using unlisted codes:

- As is the case with all claims, do not unbundle procedures that are included in a global surgery.
- Do not use modifier 22 on unlisted procedure codes.
- Do not report more than one unlisted procedure code per operative session.
- Payment delays are likely, as the payer may perform a more detailed review of your claim when an unlisted code is submitted.
- Make certain your documentation is fully supportive of the service and clearly describes the work performed, especially if it "deserves" a significantly higher reimbursement than the base code.

For additional coding guidance and resources, visit the Academy's coding corner at: http://bit.ly/ENTcoding

The Academy's CPT Team and Health Policy staff are contiually working to ensure members have access to the most up-to-date coding changes for otolaryngology-head and neck surgery. Take advantage of the resources available to you in our coding corner today.

> -Bradley Marple, MD AAO-HNS CPT Advisor

Lessons Learned in Honduras

Stephen Nogan, MD Ohio State University

n September 7, 2013, I returned from a one-week surgical mission trip to Guaimaca, Honduras, thanks in no small part to the support I received from the American Academy of Otolaryngology— Head and Neck Surgery Foundation. It was a highly successful trip with many patients treated, and the experience laid the groundwork for future international missions in my own career.

My first glimpse into international surgical missions came at the age of 20 during my undergraduate studies. I traveled into a Mexican village with 100 strangers and no clear career path, and I left at the end of the trip with many new friends and mentors and a determination to pursue a career in surgery. One of those new friends was **David S**. **Parsons, MD**, a pediatric otolaryngologist from Charlotte, NC, whom I joined on several subsequent trips to Mexico and who was the team captain for my recent trip to Honduras.



One of our patients after endoscopic sinus surgery to remove severe polyp disease with Steve Nogan.

Guaimaca is a municipality in the department (state) of Francisco Morazán in the central part of the country. Honduras has more than 8 million people, more than 50 percent of whom are living under the poverty line and more than 25 percent of whom are unemployed. Guaimaca is no exception to these national statistics. Within Guaimaca exists a hospital, Hospital Bautista, on a mission compound built with private donations and equipped with four brand new operating rooms that



OR Team. (L to R) Carole Brese, Steve Nogan, Susie Willis, Robert Willis, Monica Burciu, and Paul Downing.

Dr. Parsons, **Harvey M. Tucker**, **MD**, **Robert A. Willis, MD**, **Christopher L. Tebbit, MD**, **Tabitha L. Galloway, MD**, and I were the first to use.

We performed approximately 65 surgeries over the course of four days and distributed hundreds of medications. The operating rooms were fully staffed by U.S. volunteers, and we received additional, incredible support from Honduran physicians, nurses, translators, and security guards throughout the week. Operations included tonsillectomies, adenoidectomies, septoplasties, endoscopic sinus surgery, endoscopic

laryngeal surgery,

tympanoplasties,

a thyroidectomy, a

parotidectomy, and

various soft tissue

limited mission

work in the past, the

biggest surprise to

me on this trip was

the quality of the

Having done some

excisions.

Sistrunk procedures,



One of our pediatric patients enjoys a treat after surgery.

facility. In an area where the local residents had no clean water and inadequate plumbing and electricity, we were able to operate in a facility that met U.S. standards in these capacities. This was truly extraordinary. Because of the high quality of the hospital and, more important, the high character of the Honduran and American volunteers involved, I know we were able to impact the patients in a big way and will continue to do so on future trips. Our friendships with the missionaries and permanent volunteers at the hospital and nearby orphanages will allow us to accurately gauge our impact throughout the coming year and improve the effectiveness of the care we will provide in Honduras going forward.

In the big picture of international surgical mission work, there will never be two experiences that are the same, neither in the impact on the volunteer nor the impact on the patients. In many instances, the longterm effectiveness of a short-term experience is difficult to measure, making evaluation and validation of our work challenging. Furthermore, it is impossible to account for all variables in this type of setting. Things like safety, natural resources, medical equipment, and surgical complications can change or arise in an unpredictable fashion, all of which can have an impact on patient care. However, I do believe there are aspects of this type of mission work that you can control. Strong leadership, high character, and loyalty to the cause and the patients are the most important of these and can overcome the inevitable challenges of short-term mission work.

Much thanks to Baptist Medical & Dental Mission International (BMDMI), our sponsoring organization, for hosting us during our week in Honduras and the AAO-HNSF Humanitarian Efforts Committee for graciously helping with funding.

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The Department of Otorhinolaryngology – Head and Neck Surgery at Rush University Medical Center, located in downtown Chicago, is seeking applicants for Section Chief of Head and Neck Oncologic Surgery and Director of the Head and Neck Cancer Program. Qualified candidates must have completed an approved fellowship and be BC/BE. Experience in all aspects of head and neck surgical oncology, including microvascular reconstruction, transoral robotic surgery, and endocrine surgery is desired. Candidates must possess a strong commitment to patient care, resident education, and research. Candidates will be considered eligible for faculty appointment at all academic levels.

Rush University Medical Center is a large tertiary academic medical center located in downtown Chicago that encompasses a 664-bed hospital serving adults and children, including the Johnston R. Bowman Health Center and a new 376-bed hospital building known as the Tower. The Medical Center offers more than 70 highly selective residency and fellowship programs in medical and surgical specialties.

Rush is consistently ranked as one of the nation's top hospitals by U.S. News & World Report. Rush is ranked in 9 of 16 categories in the 2013 U.S. News & World Report's annual "American's Best Hospitals" issue and is ranked No. 2 in Illinois. Rush was the first hospital in Illinois serving adults and children to receive Magnet status – the highest honor in nursing – and the first in Illinois to earn a third four-year designation.

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Our 40 state-of-the-art clinical sites are located in growing communities across NY and NJ, where smart young medical minds are both needed and appreciated. At present, we have a select number of openings for general otolaryngologists as well as laryngologists, neurotologists, sleep specialists, rhinologists and other sub-specialists.



Wayne Eisman, MD, FACS President, ENT and Allergy Associates (914-333 5809/weisman@entandallergy.com)

Bob Glazer CEO, ENT and Allergy Associates (914-490-8880/rglazer@entandallergy.com) Dr. Douglas Leventhal, who practices out of our Oradell, NJ office, joined ENTA in 2012 after completing a residency in Otolaryngology-Head & Neck Surgery at Thomas Jefferson University Hospital in Philadelphia, PA and a fellowship in Facial Plastic & Reconstructive Surgery at New York University in New York, NY.



OTOLOGIST/NEUROTOLOGIST

The Division of Otolaryngology-Head & Neck Surgery in the Department of Surgery is seeking a fellowship-trained Otologist/Neurotologist to join our dynamic academic practice at a time of unprecedented growth and development within the division. The candidate will be able to qualify for faculty appointment at the Assistant Professor or Associate Professor level, commensurate with his/her level of experience.

The successful candidate must be a highly motivated individual with interests and capability in all aspects of medical and surgical otology and neurotology. Responsibilities include serving as Director of Otology/Neurotology, and leading a group of 3 doctorate-level Audiologists with high-level training in hearing and balance disorders, as well as cochlear implantation. The candidate will work closely and collaborate with the Department of Neurosurgery and be an integral part of the skull base surgery team. The candidate will also serve as Medical Director of Audiology Services in the health system.

Our division currently has 7 otolaryngologists, 3 Nurse Practitioners and 3 Audiologists and is expanding. We are actively engaged in medical student teaching and training residents within the hospital. Our plan is to obtain a residency program in the near future. Opportunities are available for those interested in clinical/basic science research, especially in regenerative medicine, which is the focus of the laboratory.

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Interested applicants should contact:

Nadir Ahmad, MD, FACS

Division Head, Otolaryngology-Head & Neck Surgery Three Cooper Plaza, Suite 404 Camden, NJ 08103 Email: <u>ahmad-nadir@cooperhealth.edu</u>

PEDIATRIC OTOLARYNGOLOGIST

The Division of Otolaryngology-Head & Neck Surgery in the Department of Surgery is seeking a fellowship-trained **Pediatric Otolaryngologist** to join our dynamic academic practice at a time of unprecedented growth and development within the division. The candidate will be able to qualify for faculty appointment at the Assistant Professor or Associate Professor level, commensurate with his/her level of experience.

The successful candidate must be a highly motivated individual with interests and capability in all aspects of medical and surgical pediatric otolaryngology. Responsibilities include serving as Director of Pediatric Otolaryngology, and leading the focus of all aspects of pediatric otolaryngology within Cooper University Hospital. Candidates have no restrictions and are free to practice any aspect of pediatric otolaryngology including: cochlear implantation, airway reconstruction, and craniofacial surgery. The otolaryngologists truly welcome all advanced skill sets and will work as a group to facilitate the clinical and academic growth of the candidate.

Our division currently has 7 otolaryngologists, 3 Nurse Practitioners and 3 Audiologists and is expanding. We are actively engaged in medical student teaching and training residents within the hospital. Our plan is to obtain a residency program in the near future. Opportunities are available for those interested in clinical/basic science research, especially in regenerative medicine and stem cell research, which is the focus of the laboratory.

Cooper University Hospital, the clinical campus of Cooper University of Rowan University, is the leading provider of health services to Southern New Jersey. Cooper's main hospital is located in Camden, NJ, right across the river from Philadelphia. Cooper also has satellite offices in the surrounding suburbs, including Cherry Hill, Moorestown, Voorhees and Washington Township with a surgery center based in Voorhees.

The location is ideal and in close proximity to Philadelphia, New York City, the Jersey shore and its beaches, Baltimore, and Washington DC

This is an outstanding and unique opportunity for a Pediatric Otolaryngologist to establish, lead and grow an academic practice and to be part of the development of a residency program.

Academic appointment and compensation is commensurate with training and experience.

Interested applicants should contact:

Nadir Ahmad, MD, FACS

Division Head, Otolaryngology-Head & Neck Surgery Three Cooper Plaza, Suite 404 Camden, NJ 08103 Email: <u>ahmad-nadir@cooperhealth.edu</u>



Fellowship Trained BC/BE Neuro-Otologist

Albany ENT & Allergy Services is a well-established Otolaryngology-HNS-Allergy practice in upstate New York's Capital Region with diverse ancillary services including audiology, allergy testing and immunotherapy, speech and swallowing therapy, CT imaging and sleep laboratory with convenient access to ambulatory and hospital based surgery centers. As the largest ENT practice in the region, our physicians address the full spectrum of Otolaryngology; however, this region is underserved in Neuro-Otology, and our large catchment area presents a wide range of Neuro-Otologic conditions that would benefit from fellowship level care.

Located in a newly constructed medical park, AENT is an innovative and progressively managed practice (~30,000 sq. feet) utilizing electronic health records, digitized file storage & PACS.

AENT is a member of the CHEER network and is actively involved in multiple clinical trials facilitated by our research nurse coordinator, offering many opportunities for both research and academic involvement.

The practice's audiology services include 4 clinical audiologists (AuD) and state-of-the-art audio-vestibular testing with room for expansion to include a cochlear implant program or other Neuro-Otology services.

A supportive clinical staff includes seven physicians, four physician assistants, four audiologists (AuD), speech pathologist, radiology technician, clinical research coordinator as well as a large allergy staff.

A full patient schedule, call 1:8, generous compensation and benefits including 401k and profit sharing plan, as well as partnership potential await gualified candidates.

Please send confidential inquiries to: Deborah Elia Practice Manager 518.701.2070 delia@albanyentandallergy.com





🕱 Penn Medicine

Assistant or Associate Professor, ORL-HNS Otorhinolaryngology: Head and Neck Surgery

The Children's Hospital of Philadelphia and the Department of Otorhinolaryngology: Head and Neck Surgery at the Perelman School of Medicine at the University of Pennsylvania seek candidates for several Assistant or Associate Professor positions in either the non-tenure clinician-educator track or the non-tenure academic-clinician track. Track and rank will be commensurate with experience. The successful applicant will have experience in the field of Otolaryngology with a focus on Pediatric Otolaryngology. Responsibilities include patient/ clinical care, research, and participation in medical student, resident, and fellow education. Applicants must have an M.D. or M.D./Ph.D. degree and have demonstrated excellent qualifications in education, research, and clinical care. While evidence of scholarship is required in the clinician-educator track, research is not required in the academic clinician track. Applicants must be certified by the American Board of Otolaryngology.

Candidates must have completed a fellowship in Pediatric Otolaryngology. The primary location of this position will be at The Children's Hospital of Philadelphia.

We seek candidates who embrace and reflect diversity in the broadest sense. The University of Pennsylvania and The Children's Hospital of Philadelphia are equal opportunity, affirmative action employers.

Apply for this position online at: http://www.med.upenn.edu/apps/faculty_ad/index.php/g329/d3318

Full Time Faculty Opportunities University of Rochester Medical Center

Clinician-Scientist / Neurotologist

BC/BE, fellowship trained boarded neurotologist with appropriate research training at any rank is sought to develop an outstanding clinical practice and externally funded research program and join three other practicing neurotologists. Applicants must also contribute to resident and medical student education. Basic, translational, or patient-oriented research programs are desired. Protected research time and resources are available.

Pediatric Otolaryngologist

BC/BE, fellowship trained pediatric otolaryngologist at any rank is sought to practice at the brand new Golisano Children's Hospital, opening in 2015. This position offers excellent opportunities to practice the full range of the specialty in state of the art facilities. Resident teaching is expected and scholarly activities strongly encouraged. Protected research time and resources are available for candidates seeking a career as a clinician-scientist.

General Otolaryngology

BC/BE otolaryngologists with broad clinical interests are sought to develop a general otolaryngology practice in a community setting with full academic support. Our robust clinical practice and training program is affiliated with the University of Rochester Medical Center's Strong Memorial and Highland Hospitals. These are excellent opportunities to practice with an established group of academic faculty who already have



practices in all Otolaryngology subspecialty areas, in a growing academic department.

The University of Rochester is an affirmative action/equal opportunity employer and strongly encourages applications from women and minorities.

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 Strong Memorial Hospital 601 Elmwood Avenue, Box 629 Rochester, NY 14642 (585) 758-5700 shawn_newlands@urmc.rochester.edu



- Competitive production incentive
- Research interests encouraged and supported
- New outpatient clinic with state-of-the-art equipment and ancillary services
- Well established and expanding hospital system
- Live and work in Columbia, ranked by *Money* magazine and *Outside* magazine as one of the best cities in the U.S.

For additional information about the position, please contact: Robert P. Zitsch III, M.D. William E. Davis Professor and Chair Department of Otolaryngology—Head and Neck Surgery University of Missouri—School of Medicine One Hospital Dr MA314 DC027.00 Columbia, MO 65212 zitschr@health.missouri.edu

> To apply for a position, please visit the MU web site at hrs.missouri.edu/find-a-job/academic/

The University of Missouri is an Equal Opportunity/Affirmative Action Employer and complies with the guidelines of the Americans with Disabilities Act of 1990. To request ADA accommodations, please contact (573) 884-7282 (VITTY). Diversity applicants are encouraged to apply. utmb Health

Otolaryngologic Allergist FULL-TIME BC/BE FACULTY

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting qualified candidates for a full-time academic position, which carries opportunities to participate in all aspects of clinical practice, teaching, and research. Excellent research resources are available. The position is suitable for full-time clinician-educators or clinician-scientists. We offer competitive salary, incentive, and generous benefits packages.

Please direct your Letter of Interest and CV to: Vicente Resto, MD, PhD, FACS Chair, Department of Otolaryngology The University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-0521 Email: varesto@utmb.edu Phone: 409-772-2701 Fax: 409-772-1715

UTMB is an equal opportunity, affirmative action institution which proudly values diversity. Candidates of all backgrounds are encouraged to apply.

A position is available at the Assistant or Associate Professor level in the Department of Otolaryngology

Head and Neck Surgeon

Fellowship Training Required Interest in Reconstruction Preferred

To apply and receive additional information about the support associated with this opportunity, please send a curriculum vitae to:

David J. Terris, M.D., F.A.C.S. Chairman Dept. of Otolaryngology—Head & Neck Surgery 1120 Fifteenth Street, BP-4109 Augusta, Georgia 30912-4060

or e-mail dterris@gru.edu



GRU is an Equal Opportunity, Affirmative Action and Equal Access employer.

POSITION AVAILABLE

Georgia Regents University Augusta

Department of Otolaryngology/ Head & Neck Surgery



"Love life. Step into financial success and clinical satisfaction while surrounding yourself with all the beauty and activities the Jersey Shore has to offer."

Fellowship trained Neurotologist, Head and Neck Surgeon and Rhinologist

Coastal Ear, Nose and Throat (Coastal) is an extremely successful three physician private practice located along the shore in Central New Jersey. Coastal's award winning team consists of a two General Otolaryngologists and a fellowship- trained Pediatric Otolaryngologist. We are currently searching for a fellowship trained Neurotologist, Head and Neck Surgeon and Rhinologist to assist in meeting the patient demand for our established, growing practice.

Coastal is associated with the 610-bed Jersey Shore University Medical Center (JSUMC). JSUMC is the academic center of Meridian Health and is the university affiliate of UMDNJ Robert Wood Johnson School of Medicine. Coastal ENT's 11,000 sq ft office and ambulatory surgery center offer state –of- the- art facilities close to the medical center. Ancillary services include: Allergy and Research, full time Clinical Research Coordinator on staff, Vestibular Physical Therapist on site and fully Integrated EMR. Compensation and benefits are highly competitive. Financials are transparent from recruitment to partnership.

Monmouth and Ocean Counties are desirable New Jersey shore communities in close proximity to New York City and Philadelphia. Please feel free to visit our website at www.coastalearnoseandthroat.com.



For immediate consideration, please submit your CV to: Carol A. Petite In House Physician Recruiter Meridian Health cpetite@meridianhealth.com 732-673-5000

JOIN SANFORD EAR, NOSE & THROAT CLINIC

SANF BRD

Sanford Health is seeking BC/BE Ear, Nose and Throat specialists to join a fast-paced, physician-led practice in the upper Midwest where there is opportunity to grow your patient base rapidly. Locations include Minnesota, North Dakota and South Dakota.

General – Bemidji, MN; Bismarck, ND; Fargo, ND; Aberdeen, SD; Sioux Falls, SD Pediatric – Fargo, ND

We offer a competitive salary and comprehensive benefits package, paid malpractice and relocation assistance. Communities offer high quality of life, affordable living, culture and education.

At Sanford Clinic, our talented and diverse team of dedicated physicians creates a strong foundation of excellence. With more than 1,400 primary and specialty care physicians, 140 locations, and 80 specialties, Sanford Health is the largest not-for-profit rural health care system in the nation.

Connie Long Bismark (701) 323-5417 connie.long@sanfordhealth.org

Rev. 9/13

500-51030-0114

Celia Beck Bemidji (218) 333-5056 celia.beck@sanfordhealth.org Kathryn Norby Fargo (701) 417-4851 kathryn.norby@sanfordhealth.org Jessilyn Healy Sioux Falls/Aberdeen (605) 328-6986 jessilyn.healy@sanfordhealth.org

Go to: practice.sanfordhealth.org for a listing of all of our opportunities.



GENERAL OTOLARYNGOLOGY



The Department of Otolaryngology at the Massachusetts Eye and Ear Infirmary seeks a qualified candidate for a full time position with principal location at its Stoneham Center for Otolaryngology-Head and Neck Surgery. The successful candidate would have the opportunity for a broad clinical practice in General Otolaryngology. In addition, there are opportunities to participate in basic and clinical research and/or teaching within the Infirmary and the Department of Otology and Laryngology at Harvard Medical School. The successful candidate must be board-certified or board-eligible in Otolaryngology.

> Qualified female and minority applicants are encouraged to apply.

Please send a letter of interest and curriculum vitae to:

David M. Bowling, M.D. Massachusetts Eye and Ear Associates One Montvale Avenue Stoneham, Massachusetts 02180 (781) 279-2788 david_bowling@meei.harvard.edu

Rutgers

New Jersey Medical School

Faculty Position, Otology/Neurotology Department of Otolaryngology-Head and Neck Surgery

Rutgers New Jersey Medical School, Department of Otolaryngology-Head and Neck Surgery is recruiting a fellowship-trained Otologist/ Neurotologist faculty member for July 2014. The successful applicant will join a rapidly growing academic department, and will be expected to contribute to its clinical, educational and research activities. The Department houses the only allopathic residency training program in New Jersey and collaborates with an extensive array or health care providers across the Rutgers Biomedical and Health Sciences units.

Applicants for this position must be able to perform at a high level both clinically and academically. Salary will be commensurate with ability, training, experience and demonstrated prior performance, and is designed to attract an outstanding physician and surgeon.

Submit inquiries and current Curriculum Vitae to:

Soly Baredes, M.D. Professor and Chairman And Aaron Hajart, MS, ATC Sr. Director of Administration

Rutgers New Jersey Medical School Department of Otolaryngology-Head and Neck Surgery 90 Bergen Street, Suite 8100 Newark, NJ 07103 (973) 972-2341 hajartaf@njms.rutgers.edu



2 FACULTY POSITIONS Rhinology and Laryngology

Department of Otolarygology - Head and Neck Surgery

RHINOLOGY - TENURED OR TENURE-ELIGIBLE

This position will be responsible for teaching medical students and residents, participating in rhinology clinical research and providing clinical services in both outpatient and OR settings. Salary, rank and tenure status will be dependent on qualifications and experience. Candidates must have an MD and be board-eligible or board-certified in Otolaryngology as well as have completed a fellowship in rhinology. For consideration for the tenure-eligible position, candidates must have strong clinical skills, as well as documented excellence in patient care, teaching or research. To be considered for the tenured position, candidates must demonstrate scholarship and excellence in two domains consistent with the requirements for tenure in the School of Medicine.

To apply for the tenure-eligible position, visit https://jobs.virginia.edu and search on Posting Number 0610427. To apply for the tenured position, visit https://jobs.virginia.edu and search on Posting Number 0610468.

LARYNGOLOGY - TENURE-ELIGIBLE

This tenure eligible position will be responsible for teaching medical students and residents, participating in laryngologic and swallowing disorders research, and providing clinical services in both outpatient and OR settings. This position will also take a lead role in the development of a multi-disciplinary swallowing center. Rank will be dependent on qualifications and experience. Candidates must have an MD and be board-eligible or board-certified in Otolaryngology, as well as have completed a fellowship in laryngology.

To apply, visit https://jobs.virginia.edu and search on Posting Number 0609465.

For both positions, complete a Candidate Profile online, attach a cover letter, curriculum vitae and contact information for three references. Please also attach a copy of your surgical case log from residency, fellowship or last three years of practice.

Positions will remain open until filled. For further information regarding the application process,

please contact: Jennifer Oliver, via e-mail jmo8n@virginia.edu or telephone 434-243-3697.

The University of Virginia is an Equal Opportunity/ Affirmative Action Employer strongly committed to achieving excellence through cultural diversity. The University actively encourages applications and nominations from women, minorities, veterans and persons with disabilities.



Head and Neck Fellowship

Clinical Focus: Head and neck surgical oncology, skull base surgery, endoscopic laser surgery, minimally invasive endocrine surgery, microvascular reconstructive surgery and robotic surgery

Applications are accepted through the American Head and Neck Society: www.ahns.info

To view position online, go to http://jobs.kumc.edu and search by position number.

Letters of inquiry and CV may be mailed or emailed to:

Dan Bruegger, MD, Associate Professor and Interim Chairman The University of Kansas School of Medicine Department of Otolaryngology-Head & Neck Surgery 3901 Rainbow Blvd, MS 3010, Kansas City, KS 66160 Email: dbruegge@kumc.edu



General Otolaryngologist

University of Utah Otolaryngology—Head & Neck Surgery seeks a BC/BE faculty with an interest in general otolaryngology. This is a full-time clinical track position at the Assistant Professor level. Responsibilities will include teaching, research and clinical care in our community clinics. Position available July 2014.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/ humanResources/5-106.html.

Applicants must apply at: http://utah.peopleadmin.com/postings/18379 *For additional information, contact:* Clough Shelton, MD, FACS, Professor and Chief University of Utah School of Medicine 50 North Medical Drive 3C120 Salt Lake City, Utah 84132 Phone: (801) 585-1626 Fax: (801) 585-5744 E-mail: inga.journey@hsc.utah.edu

Otolaryngologist Opportunity

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is seeking a BC/BE Otolaryngologist.

Geisinger's otolaryngology specialists treat a wide range of conditions of the head and neck by providing the latest technologies in diagnostic, medical, surgical and rehabilitative techniques. We have board-certified and fellowship-trained specialists who collaborate to ensure the most comprehensive care.

About the Position

- Take part in the growth of this dynamic department
- Teach residents
- Pursue research in your area of interest

Medical school loan repayment and residency and fellowship stipends are available.

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is an acute care hospital that is licensed for 243 beds and houses the only Level II Trauma center in Luzerne County. The campus includes the Frank M. and Dorothea Henry Cancer Center, The Richard and Marion Pearsall Heart Hospital, the Janet Weis Children's Hospital Pediatric Unit, a transplant program and the Brain & Spine Tumor Institute. GWV is affiliated with an accredited Otolaryngology residency program.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information, please visit Join-Geisinger.org or contact: Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu.

Follow us: **f** Linked in

GEISINGER

MD/DO ENT, BE/BC Central Oregon ENT

Bend, OR sits on the eastern slopes of the Cascade Mountains in Central Oregon's high mountain desert and enjoys 300 days of sunshine. We are surrounded by year round outdoor activities including world class skiing, fishing, water sports, golf and rock climbing. Bend's small town family atmosphere is home to rich cultural, excellent educational and exciting entrepreneurial opportunities. Escape to the "big city" of Portland a few hours away.

Central Oregon ENT, since 1964, is a full service clinic with six physicians and two audiologists plus a full range of support services and experienced staff. Our focus includes general ENT, Sinus and Skullbased surgery, Head & Neck, Voice & Swallowing, Allergy, Audiology and Hearing Aids. We have a large existing patient population and strong referral base with two offices plus satellite offices, we serve all of Central and Eastern Oregon; our greater area has a population of over 200,000. Our practice emphasizes community based otolaryngology care and practices excellent, compassionate clinical care.

We are recruiting a BE/BC MD/DO ENT to become part of our practice. Candidate will have strong interest/focus or be fellowship trained in Head/Neck disease and surgery. We offer a full benefit package and generous salary structure. We are financially stable and have proven and successful track to full partnership. CONTACT: Lorin Easly Central Oregon ENT, LLC 2450 NE Mary Rose Place, Ste 120

Bend, Oregon 97701 leasly@coent.com

Children's Mercy Kansas City

Kansas City's Children's Mercy Hospital and Clinics, in affiliation with the University of Missouri-Kansas City, is seeking fellowship trained Pediatric Otolaryngologists. Our current faculty includes 7 Pediatric Otolaryngologists and 3 Neurotologists. Our robust Division is dedicated to providing comprehensive treatment to patients in a family centered care environment. With the completion of the new patient tower at our Missouri based hospital, we have expanded to 400 beds increasing the PICU capacity to 41 beds and the NICU to 80 beds.

The responsibilities of this position include clinical care, research, and teaching medical students and the residents in our Pediatric and Otolaryngology programs. Salary and academic range are commensurate with experience. EOE/AAP

Kansas City is a metropolitan area of more than two million people spanning the Missouri–Kansas border. It has an extensive offering of arts, entertainment, and sports with a number of new venues having just opened within the past few years. K C is home to several major colleges and universities. Our metropolis contains a wide selection of highly rated public and private schools.

For more information check us out at www.childrensmercy.org or contact:

Robert A. Weatherly, MD; Division Director; Ear, Nose, and Throat rweatherly@cmh.edu Phone: 866-CMH-IN-KC/866-264-4652

KANSAS CITY, a GREAT place to Live and Work!! http://www.thinkkc.com/livingworking/livingworking.php

Join A Well Established Practice In North Carolina

Our ENT practice is seeking a BC/BE Otolaryngologist to join our current five-physician practice. This practice enjoys a full spectrum of ENT services including head and neck surgery, otology, allergy testing and treatment, CT scanner on site, EHR (Electronic Health Records), audiology and hearing aid dispensing.

Our benefit package includes excellent starting salary with partnership anticipated after two years, 401(k), professional liability insurance, and health insurance.

Interested individuals should send Curriculum Vitae to: Fayetteville Otolaryngology Head & Neck Surgery, P.A. 1839 Quiet Cove Fayetteville, N.C. 28304

> Phone (910) 323-1463 Fax (910) 222-6551 Website: fayent.com Email: gparksfayent@nc.rr.com

Contact: Elizabeth Hueman, M.D. or Gwendolyn Parks, Practice Administrator.

Two General Otolaryngologists Needed in Charlotte NC

Charlotte Eye Ear Nose and Throat Associates, PA (CEENTA) is a multi-specialty practice of Ophthalmology and Otolaryngology. Our 90 year old practice has 78 providers and 14 offices spread over a geographic area with a radius of approximately 50 miles centered on Charlotte NC.

Due to continued expansion, CEENTA has openings for 2 General Otolaryngologists in the greater Charlotte metro region.

The group has all subspecialties represented, an established referral base, and an in-house contract research organization.

Charlotte is two hours east of the Appalachian Mountains and 3 1/2 hours west of the Atlantic Ocean. It is home to the University of North Carolina, Charlotte, the NFL Panthers, the NBA Bobcats and a variety of cultural venues. Charlotte and its metropolitan area, have one of the fastest growing populations of mid-sized metropolitan areas in the United States.

Excellent salary with partnership anticipated, robust 401(k) and profit sharing plan, professional liability insurance, health insurance, long term disability and life insurance.

For immediate consideration, please send CV to:

anash@ceenta.com or Director-Human Resources Charlotte Eye Ear Nose and Throat Associates, PA. 6035 Fairview Road Charlotte, NC 28210

Fax: (704)295-3415

EOE



Charlotte Eye Ear Nose & Throat Associates, P.A.

WORK FOR THE BEST.

FELLOWSHIP TRAINED HEAD AND NECK SURGEON

Cancer Treatment Centers of America is currently seeking a full time BC/BE surgeon with a fellowship in otolaryngology, or plastic surgery with experience with the multidisciplinary care delivery for patients with head and neck cancer. You will work collaboratively with our current team of medical and surgical oncologists, as well have the support of hospitalists, an assigned mid-level provider, nutritional support services and ONS-trained nursing staff.

In this employed hospital opportunity, we offer a competitive salary and comprehensive benefits package, including paid medical malpractice, matching 401 (k) plan, health insurance for you and your family, CME, vacation and relocation package. You will have an onsite office and use of electronic medical records.

Our hospital is located between downtown Chicago and Milwaukee with access to both metropolitan areas, as well as amenities that include world-class art museums and theater, professional sporting events, excellent schools and outstanding universities.

Contact: Drexa Unverzagt, RN, MS National Director of Physician Recruitment' Cancer Treatment Centers of America 847-746-4384 drexa.unverzagt@ctca-hope.com EOE



Winning the fight against cancer, every day.®



UNIVERSITY of CALIFORNIA · IRVINE

SCHOOL OF MEDICINE DEPARTMENT OF OTOLARYNGOLOGY, HEAD AND NECK SURGERY

The University of California Irvine Department of Otolaryngology – Head and Neck Surgery is seeking a full-time faculty in a 0.5 tenured position and 0.5 In Residence position at the assistant, associate, or professor level. The successful candidate will have a primary research focus in hearing sciences, and have or be able to secure grant funding as well as pursue focused research that will meet promotion criteria for the tenured faculty series. Academic appointment at Assistant, Associate or Professor Rank will be recommended based on training and experience.

The applicant must be fellowship trained in Neurotology and be able to work well in a multidisciplinary setting. The successful candidate must have excellent patient care skills, demonstrated talent and commitment to hearing research, and enthusiasm for teaching.

Candidates must have MD degree and California medical license. More information on the department can be found at <u>http://www.ent.uci.edu/</u>

Submit your online application and complete curriculum vitae, and 3 or more references by logging in to UC Irvine's RECRUIT System, located at: https://recruit.ap.uci.edu/apply/

For further information pertaining to this recruitment please contact: William B. Armstrong, Professor & Chair 101 The City Drive South, Building 56, Suite 500 Orange, California 92868-5386 Phone: 714-456-5750 Fax: 714-456-5747 Email: wbarmstr@uci.edu

The University of California, Irvine is an equal opportunity employer committed to excellence through diversity and strongly encourages applications from all qualified applicants, including women and minorities. UCI is responsive to the needs of dual career couples, is dedicated to work-life balance through an array of family-friendly policies, and is the recipient of an NSF ADVANCE Award for gender equity.



Head and Neck Oncology Surgeon/Scientist

University of Utah Otolaryngology—Head & Neck Surgery seeks BC/BE faculty with fellowship training in head and neck oncology. This is a full-time tenure track position at the Assistant or Associate Professor level. Must have MD PhD, additional research training (T-32) or competitive, extramural funding. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available immediately.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at: http://utah.peopleadmin.com/postings/19713 For additional information, contact: Clough Shelton, MD, FACS, Professor and Chief University of Utah School of Medicine 50 North Medical Drive 3C120 Salt Lake City, Utah 84132 Phone: (801) 585-1626 Fax: (801) 585-5744 E-mail: inga.journey@hsc.utah.edu

Southern New England

Otolaryngologist/Subspecialty Interests Welcome

ProHealth Physicians is currently seeking an Otolaryngologist to join an established ENT practice in Bristol, Connecticut. Bristol is the home to ESPN and is a suburban community conveniently located 30 minutes from the cities of Hartford/New Haven CT and halfway between New York City and Boston Massachusetts (*2 hours to either city*). The surrounding area has excellent school systems and ample recreational opportunities.

Currently the group has 4 ENT physicians including subspecialists in rhinology and otology. Interest is in a comprehensive otolaryngologist, but complementary subspecialty interests are welcomed. Excellent compensation and benefits package offerings.

Forward CV to Debra Colaci ProHealth Physician Recruiting 860-284-5333 (Fax) dcolaci@prohealthmd.com



www.ProHealthMD.com



The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 2014 or sooner. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIHfunded research division with three PhD members.

With a metro area population of over 115,000, Morgantown, WV, is consistently rated as one of the best small cities in the U.S., with affordable housing, excellent schools, a picturesque countryside, many outdoor recreational activities, and close proximity to major cities, such as Pittsburgh, PA, and Washington, DC.

The position will remain opened until filled. For more information please contact:

Laura Blake Director, Physician Recruitment blakel@wvuhealthcare.com Fax: 304.293.0230 http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.



GENERAL OTOLARYNGOLOGY



The Department of Otolaryngology at the Massachusetts Eye and Ear Infirmary seeks a qualified candidate for a fulltime position with principal location at its Concord Center for Otolaryngology-Head and Neck Surgery. The successful candidate would have the opportunity for a broad clinical practice in General Otolaryngology. In addition, there are opportunities to participate in basic and clinical research and/or teaching within the Infirmary and the Department of Otology and Laryngology at Harvard Medical School. The successful candidate must be board-certified or board-eligible in Otolaryngology.

> Qualified female and minority applicants are encouraged to apply.

Please send a letter of interest and curriculum vitae to:

Stephen Smith, M.D. Massachusetts Eye and Ear Associates 290 Baker Avenue Concord, Massachusetts 01742 (978) 369-8780 stephen_smith@meei.harvard.edu



Pediatric Otolaryngology Surgeon/Scientist

University of Utah Otolaryngology–Head & Neck Surgery seeks BC/BE faculty with fellowship training in Pediatric Otolaryngology. This is a full-time tenure track position at the Assistant or Associate Professor level. Must have MD PhD, additional research training (T-32) or competitive, extramural funding. The successful candidate should be able to lead an extramurally-funded research effort and also participate in clinical care and resident education. Position available July 2014.

The University of Utah is an Equal Opportunity/ Affirmative Action employer and educator. Minorities, women, and persons with disabilities are strongly encouraged to apply. Veterans preference. Reasonable accommodations provided. For additional information: http://www.regulations.utah.edu/humanResources/5-106.html.

Applicants must apply at: http://utah.peopleadmin.com/postings/20311 For additional information, contact: Clough Shelton, MD, FACS, Professor and Chief University of Utah School of Medicine 50 North Medical Drive 3C120 Salt Lake City, Utah 84132 Phone: (801) 585-1626 Fax: (801) 585-5744

E-mail: inga.journey@hsc.utah.edu



NewYork-Presbyterian Hospital
Weill Cornell Medical Center



ACADEMIC LARYNGOLOGY IN NEW YORK CITY

Join the newly-established Sean Parker Institute for Voice Disorders in the Department of Otolaryngology-Head and Neck Surgery at Weill Cornell Medical College. Applicants should be fellowship trained in laryngology and have a strong interest in clinical and translational research.

Opportunities include:

- Help build a first-class clinical and research laryngology program in the performing arts, media and business hub of the nation.
- · State-of-the-art ambulatory care facitilies
- · Ivy League medical school
- Top 10 rated academic hospital
- Faculty housing available

If interested, please contact Lucy Georgeou at lbg2002@med.cornell.edu

EOE M/F/D/V



The Department of Otolaryngology at West Virginia University is seeking a fellowship-trained head and neck surgeon to join a well established head and neck oncology service in the summer of 2014 or sooner. Expertise with both ablative and reconstructive procedures is desired. Responsibilities include education of residents and medical students and patient care. Opportunities are available for those interested in clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

West Virginia University is located in beautiful Morgantown, which is rated one of the best small towns in America in regard to quality of life. Located 80 miles south of Pittsburgh and three hours from Washington, DC, Morgantown has an excellent public school system and offers culturally diverse, large-city amenities in a safe, family setting.

The position will remain opened until filled. Please send a CV with three professional references to:

Laura Blake Director, Physician Recruitment Fax: 304-293-0230 blakel@wvuhealthcare.com http://www.hsc.wvu.edu/som/otolaryngology/

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

classifieds: employment [[[]]]



Rush University Medical Center, Chicago Laryngologist

The Department of Otorhinolaryngology – Head and Neck Surgery at Rush University Medical Center, located in downtown Chicago, is seeking applicants for Section Head of Laryngology and Director of the Rush Voice Care Institute. The individual will be charged with creating a center of excellence to provide comprehensive medical and surgical care for voice and swallowing disorders. Qualified candidates must have completed an approved fellowship in Laryngology and be BC/BE. Candidates must possess a strong commitment to patient care, resident education, and research. Applications will be considered eligible for faculty appointment at Assistant or Associate Professor level.

Rush University Medical Center is a large tertiary academic medical center located in downtown Chicago that encompasses a 664-bed hospital serving adults and children, including the Johnston R. Bowman Health Center and a new 376-bed hospital building known as the Tower. The Medical Center offers more than 70 highly selective residency and fellowship programs in medical and surgical specialties and subspecialties.

Rush is consistently ranked as one of the nation's top hospitals by U.S. News & World Report. Rush is ranked in 9 of 16 categories in the 2013 U.S. News & World Report's annual "American's Best Hospitals" issue and is ranked No. 2 in Illinois. Rush was the first hospital in Illinois serving adults and children to receive Magnet status – the highest honor in nursing – and the first in Illinois to earn a third four-year designation.

QRUSH Rush is an Equal Opportunity Employer

William Krech, Faculty Recruitment William_Krech@rush.edu



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