

Quarterly Report



AOCO,
AOCO-HNS &
Foundation, Inc.

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery - Winter 2006-2007, Vol. 42 No. 1



*The Colleges and their Boards wish
you a Happy Holiday and a Healthy and
Prosperous New Year!*

What's Inside This Issue:

2-3

College
Presidents
& EVP
Reports

4

Member
News

7

AAO
News
Room

12

AOA
News

13

AAO-HNS
Update

18

DO
Washington
Update

*Election and Voting Procedures
for the 2007-2008 College Boards*

AOCO Board Member Nominees

AOCO-HNS Board Member Nominees

14-17

AOCO-HNS - American Osteopathic College of Otolaryngology-Head and Neck Surgery 2006-2007 Board Members:

President: Kenneth H. Rogotzke DO
President Elect: Frank A. Brettschneider, DO
Vice President: Thomas E. Brandesky, DO
Secretary: Kirk W. Steehler, DO
Past President: David N. Madgy, DO

Members-at-Large:

Paul E. Burk, DO
Michael S. Haupt, DO
Donald M. Rothen, DO
Edward D. Scheiner, DO
Christopher L. Surek, DO
CRR Rep.: Mahmoud M. Ghaderi, DO
CRF Rep.: Jeffrey G. Coury, DO

AOCO - American Osteopathic College of Ophthalmology 2006-2007 Board Members:

President: Jacques L. Surer Jr., DO
President-Elect: Shoib Myint, DO
Vice President: Sidney K. Simonian, DO
Secretary: Jeffrey N. Holtzman, DO
President: Rudy R. Manthel, DO

Members-at-Large:

Robert J. Franchi, DO
Arin H. French, DO
David D. Gossage, DO
Michael A. Krasnow, DO
William M. McLaughlin, DO
Brian E. Wind, DO
CRR Rep.: Steven Sherman, DO
CRF Rep.: Scott M. Pfahler, DO

Executive Vice President:

Alvin D. Dubin, DO

Staff:

Debra L. Bailey, Administrative Director
Cynthia Carleton, Administrative Assistant

The [AOCOO-HNS Quarterly Report](#) is published quarterly by the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery, 4764 Fishburg Road, Suite F, Huber Heights, OH 45424, (937) 233-5653 or (800) 455-9404, FAX (937) 233-5673. Send email correspondence to: aocoohns@aol.com. The AOCOO-HNS website is located at: www.aocoohns.org.

Views and opinions expressed in the [AOCOO-HNS Quarterly Report](#) are not necessarily endorsed by the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery.

Quarterly Report Schedule

SUMMER: copy deadline May 15th
mailing June 15th
FALL: copy deadline August 15th
mailing September 15th
WINTER: copy deadline November 15th
mailing December 15th
SPRING: copy deadline February 15th
mailing March 15th

PRESIDENTS' REPORTS

AOCO-HNS

American Osteopathic College of Otolaryngology-Head and Neck Surgery
Kenneth H. Rogotzke, DO



The 2006 Mid-Year meeting was held in Philadelphia. This was a well-run meeting chaired by Dr. Mahmoud Ghaderi and Drs. Sirtaz Sibia and Sanjay Kamat. Your College Boards, Council

of Medical Education and the AOBOO-HNS all met prior to this meeting.

The new bylaws will be phased in immediately. You will see proof of streamlining the Colleges, for example, by the Nominating Committee's upcoming slate for elections.

I want to spend a little time discussing the CRR (Council of Regional Representatives). Dr. Steven Sherman (OPH) and Dr. Mahmoud Ghaderi (ENT) are your leaders. The CRR is in its second full year. The intent is (1) to be a bridge from you to the Colleges Boards, (2) to identify and develop our future leaders, (3) to be a source from the six regions of the country and their unique practices. The CRR could also become a source to help mentor new physicians moving to different regions of the country and perhaps to identify different state legislative issues that may affect all of us. Only your involvement with the CRR will make this process work.

Speaking of involvement we have an upcoming election. Ballots for voting will be included with the Spring *Quarterly Report*. PLEASE TAKE THE TIME TO VOTE—PARTICIPATE!

Finally we are "exploring the waters" for the replacement that will be needed someday for Dr. Alvin Dubin, our Executive Vice President. Dr. Carlo DiMarco is chairing a search committee for this process. This position has evolved over the years and has taken on a variety of responsibilities, particularly administrative duties, Foundation duties and of course educational duties. I would hope that talent could be found and developed from our own ranks.

Kenneth H. Rogotzke, DO
AOCO-HNS President
605-882-1672
Fax 605-882-1693
Email: rogo57201@hotmail.com

Board & Committee Reminder

The Executive Committees of the AOCOO-HNS and Foundation are meeting on Thursday, February 8th, 2007 and the following outline applies to all Board Members and Committee Chairmen.

1. Reports due January 10, 2007 for review at the February meeting.
2. Executive Committees will review reports during the February meeting.
3. The Executive Committees will prepare recommendations for review and action of the full Boards at their Annual Meetings in May.

Your reports may be faxed (937-233-5673) or emailed (aocoohns@aol.com) to the Administrative Office - please comply with the previously published deadline.

AOCOO-HNS FOUNDATION SILENT AUCTION 2007

Shoib Myint, DO, Fundraising Committee Chairman

WE NEED YOUR TIME OR TALENT

PLEASE CONTACT DEBRA BAILEY at aocoohns@aol.com or 800-455-9404 if you can donate a tax deductible item or some of your valuable time.

LOCATION: THE 2007 ACA ANNUAL MEETING BANQUET



Please consider donating items that are easily transportable or able to be shipped. Examples: time share weeks, wine, jewelry, gift certificates, etc.

REMEMBER: DONATIONS ARE TAX DEDUCTIBLE. PURCHASES ARE TAX DEDUCTIBLE.

AOCO

American Osteopathic
College of Ophthalmology

Jacques L. Surer Jr., DO



Our Mid-Year meeting in Philadelphia in September went very well. There was a good turnout of residents and medical students. The Board had a "Retreat" facilitated by Hershey Bell, MD that was very productive. It is good

to report that several new ophthalmology residency programs are coming on board.

We are all aware of the upcoming demand for care as the Medicare age group increases by 20 to 40 percent in the very near future. A recent report suggests that there will be a 50 percent increase in cataracts by 2020. Bear in mind that this also brings a financial burden to all of us. Federal, state and local governments have added nearly ten trillion dollars to taxpayer liability in the past two years. That is the equivalent of a \$510 thousand-dollar debt for every household in the United States.

The Board is still pursuing its efforts to establish an international service site for resident training. However, the process has been somewhat slower in developing than we had hoped. Issues are still being resolved and hopefully more will be reported on by our Spring meeting.

The Foundation is continuing to work on fundraising and is making an effort to be more sophisticated in its approach to corporations. Thanks to all who have contributed this past year.

I look forward to see all of you in May.

Jacques L. Surer Jr., DO
AOCO President
717-843-7829
Fax 717-854-7718
Email: jlseye@blazenet.net



New AOCOO-HNS Website

The AOCOO-HNS is pleased and proud to announce the launching of a newly designed website (www.aocoo-hns.org). If you have surfed the AOCOO-HNS website before, you'll notice that some of the most frequently visited web links are now available from the home page. Please feel free to email (aocoo-hns@yahoo.com) your comments as well as any suggestions that you may have to help make the AOCOO-HNS website a web place that you will visit frequently.

EXECUTIVE VP REPORT

Alvin D. Dubin, DO



I recently was given a copy of my inaugural address to the Osteopathic College of Ophthalmology and Otolaryngology, presented 26 years ago in Kansas City) and was

impressed that the issues stressed are as timely today as they were then. Concerns for development of additional quality programs in our specialties, the need for alternative sources for funding, the development of academic centers with research commitments to our areas of expertise, and the need for closer cooperation with our Certifying Board where areas of mutual concern exist, were all "hot issues" to be considered as priority items.

The saying "that the more things change, the more that they stay the same" was never more evident, when I reviewed those notes.

Certainly, other topics such as: political matters, socio-economic issues, advocacy, malpractice concerns, reimbursement difficulties, and others, have been vying for our attention. And yet, when I try to see more clearly areas that truly threaten our Specialties' development again, additional quality programs with sufficient funding are of prime importance to maintaining the need for Osteopathic EYE and ENT Specialists. This is necessary to fill the real need for patient care and DO Specialty support—at the present time the Board, its' Committees, and the AOA are re-thinking these topics with new input expected at the Annual AOA Meeting this July 2007.

Now I look to the present and future needs that go along with those just mentioned.

Two of the most recognized and discussed are (1) CME and (2) self-assessment. Lately these topics have taken on a new dimension when I review and try to truly understand their implications for the Colleges' and, you, the member.

CME can no longer be treated in a casual manner by Physicians. Quality presentations with workbooks given in advance, selection of trained Program Chairmen, determination of College and Certification needs in the overall selection of necessary topics, and presented in a manner that has relevancy, thoroughness, and style, are of paramount importance.

The verification of attendance with pre and post survey/examinations during the CME Presentation will do much to insure and assure the various agencies and the public, that our Physicians take Continuing Education, seriously.

It is no longer a debatable issue, we must, and will do, what is necessary to demonstrate to ourselves and others as well, that we expect no free rides in maintaining the highest standards of practice.

And now the topic of self-assessment. Everywhere I travel professionally I seem to hear about this topic. In some respects—the new buzz word, but in reality it has been there one way or another for a long time.

When Freud, brilliantly developed psychoanalysis, he obviously formulated a method of self-assessment. One of his main contributions, among the many, was the ability to truly look at himself, painfully and rather objectively. No small measure of greatness. And still a measure that is elusive for so many of us.

We are constantly being evaluated by others (a much easier process) but lag behind in our own candid and "objective" insight for ourselves. Individuals must do it, whether or not they function as solo entities, or part of a group. The attempt to truly evaluate one's ability in many areas of work, play, relationships with others, ability, motivation, positive and negative attributes, are truly best understood by one's self, if—honesty and objectivity are obtainable.

Difficult to accomplish—probably, attainable—certainly. With training, study, guidance, and a desire to succeed, we can and will develop the skills necessary to have a real understanding of ourselves, our future needs, our capabilities, our strengths and weaknesses, and to bring to our Colleges' the ability to serve our Committees, Boards, Profession, in a manner reflecting a maturity, professionalism, and success.

Of this, I have no doubt!

I wish you, and your family and friends a safe and joyous holiday season!

91st Annual Clinical
Assembly
May 2-6, 2007
Ritz-Carlton
Sarasota, FL

A Message from CMS NPI: Get It. Share It. Use It.

Over 1.4 million National Provider Identifiers (NPIs) have been issued. Do you have yours?

Think you don't need an NPI? Think again. If you are a health care provider who bills for service, you probably do need an NPI. If you bill Medicare for services, you definitely do!

The bad news is that as of November 23rd, **only six months remain** until the NPI compliance date. The implementation of the NPI is a complex process that will impact all business functions of your practice, office or institution including: billing, reporting and payment. This is why providers are urged to get, share, and use their NPI now and avoid a disruption in cash flow.

If you don't have an NPI, get one. If you have one, start the testing process with your health plan and use it on your claims and other transactions.

CMS continues to urge providers to include legacy identifiers on their NPI applications. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

KEY NPI FACTS

The Centers for Medicare and Medicaid Services (CMS) along with the Workgroup for Electronic Data Interchange (WEDI) and other industry health plans would like to remind providers of the following key NPI facts:

- Every covered health care provider must get and use the NPI; and even if a health care provider is an individual and is not conducting electronic transactions, and is, therefore, not a covered provider, he or she may be required by health plans or employers to obtain an NPI.
- The NPI is not just a number. It does affect internal and external business and systems operations and can affect the appropriate payment of claims in a timely manner.
- It is estimated that use of the NPI can require a transition period of no less than 102 days.
- Providers should begin to test and use their NPIs in electronic health care transactions no later than January 31, 2007.
- May 23, 2007 is not when the process starts, but when the process must be completed.
- Providers may be requested to communicate their NPIs to health plans, clearinghouses, and other providers well before the compliance date.

- A health care provider who is a sole proprietor is considered an individual and can only have ONE NPI.

SHARING NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that require it. In fact, as outlined in current regulation, all providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes—including designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their numbers for them.

NPIs ARE FREE!

Health care providers should know that getting an NPI is free. You do not need to pay an outside source to obtain your NPI for you. All CMS education on the NPI is also free. CMS does not charge for its education or materials.

NPI QUESTIONS

CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs: <http://questions.cms.hhs.gov/>

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an application
 - Forgotten/lost NPI
 - Lost NPI notification letter
 - Trouble accessing NPPES
 - Forgotten password/User ID
 - Need to request a paper application
- Need clarification on information that is to be supplied in the application—providers needing this type of assistance may contact the enumerator at 1-800-465-3203.

UPCOMING WEDI EVENTS

WEDI has several NPI events scheduled in the upcoming month. Visit www.wedi.org/npioi/index.shtml to learn about these events. Please note that there is a charge to participate in WEDI events.

COMMUNICATING NPIs TO MEDICARE

Medicare providers should know that there is no "special process" or need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program in three different ways, as part of the following standard procedures:

- Medicare providers should use their NPI, along with appropriate legacy identifiers, on their Medicare claims
- For new Medicare providers, an NPI must be included on the CMS-855 enrollment application

- Existing Medicare providers must provide their NPIs when making any changes to their Medicare Enrollment information.

STILL CONFUSED?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProviderStand on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

GETTING AN NPI IS FREE—NOT HAVING ONE CAN BE COSTLY.

AOCOO-HNS Member News

ROBERT B. CHAMBERS, DO

On October 26, 2006 Dr. Robert Chambers was honored at an OSU Faculty Reception to celebrate his appointment to the newly endorsed William H. Havener, MD, Chair in Ophthalmology Research.



The Havener Society was established in the late 1980s by the students of William Havener to perpetuate the principles and high standards that he set for himself and for the students and benefactors of his talents. For four decades, he had a single mission, the advancement of Ophthalmology. He was directly responsible for the training of over 100 ophthalmologists and thousands of medical students.

Dr. Chambers is an Associate Professor of Ophthalmology and the Director of the Retina Division of The Ohio State University. He has been Program Director of the Ophthalmology Training Program for 10 years. He is a graduate of the College of Osteopathic Medicine and Surgery in Des Moines, Iowa. Dr. Chambers completed his residency at Flint Osteopathic Hospital. In 1984, Dr. Chambers joined Ohio State as a fellow under Dr. Frederick H. Davidoff, specializing in vitreo-retinal diseases. Following completion of his fellowship, he joined the faculty of the Department of Ophthalmology at OSU. In 2005 and 1989, Dr. Chambers received the Bakley-Battles Teaching Award, an honor given for excellence in resident teaching awarded by the residents. Dr. Chambers is one of only two faculty members to be honored with this award twice. Also in 2005, Dr.

Chambers was awarded the College of Medicine Excellence in Teaching Award. For many years he served on the COM admissions committee as an interviewer of prospective medical students. Dr. Chambers' research interests include diabetic retinopathy, age-related macular degeneration, ocular oncology, and medical and surgical retina. He is currently principal investigator or co-investigator on approximately 17 research projects. He and his team of researchers are working to identify new drugs that will aid in the treatment of age-related macular degeneration. A National Institute of Health study that Dr. Chambers is leading focuses on the role of vitamins in age-related macular degeneration patients. The OSU Department of Ophthalmology is one of only two sites in Ohio chosen to participate in this study. Dr. Chambers has been married to his wife DeAnne for 30 years. Their two children, Chris and Megan, are following their father into medicine; one is an ophthalmology resident and the other is a medical student.

WAYNE F. BIZER, DO

During the 2006 Joint Meeting of the AAO in Las Vegas, November 11-14, Dr. Wayne Bizer was a recipient of the American Academy of Ophthalmology Achievement Award.

This Achievement Award goes to more than 100 eye doctors worldwide for their contributions to the AAO. Contributions include serving as an instructor, authoring scientific papers and posters, presenting scientific exhibits, chairing a subspecialty day and serving as a committee member, state society president, trustee and authoring or co-authoring AAO educational material.

WAYNE K. ROBBINS, DO

Dr. Robbins is developing a Temporal Bone training course to be given on March 30, 2007 hosted by the Genesys Regional Medical Center, Genesys Learning Institute. This training course is to teach innovative techniques in otologic procedures with lectures by four (4) board certified medical clinicians and a three (3) hour hands-on cadaveric lab session. Registration information is available by contacting Michele Guevara, Genesys Learning Institute Surgery Training Services Consultant at 810-606-7577 or email: mguevara@genesys.org.

MEMBERSHIP INFO

The AOOCO-HNS "Quarterly Report" is always looking for membership news, so don't be shy. If you have something of interest to report, please notify the College Office and your information will be published in the next newsletter.

AOBOO-HNS UPDATES

Voluntary and Mandatory Recertification

The American Osteopathic Board of Ophthalmology and Otolaryngology-Head and Neck Surgery (AOBOO-HNS) is required by the American Osteopathic Association to offer recertification examinations in all areas of certification including the subspecialty fields. **The AOBOO-HNS is required to notify all diplomates of this information.**

Guidelines for Voluntary Recertification: Lifetime holders of certification by the AOBOO-HNS may voluntarily seek recertification. Voluntary recertification in no way affects the lifetime certificate, pass or fail. A diplomate who successfully completes a recertification examination will be issued a ten (10) year time-dated recertification certificate. The diplomate may recertify every ten (10) years. Failure in the recertifying process will in no way result in the loss of certification for physicians holding lifetime certification.

- Diplomates certified in ophthalmology prior to January 1, 2000 hold lifetime certificates.
- Diplomates certified in otolaryngology and/or otolaryngology/facial plastic surgery prior to January 1, 2002 hold lifetime certificates.

Voluntary Recertification Requirements:

- Diplomates must be in active practice, a member in good standing with the AOA and have maintained state licensure.
- Application (letter of intent) for recertification may be made anytime prior to March 31st of the year the diplomate wishes to be recertified. All materials supplied shall remain the property of the Board. The recertification examination is administered once a year (in the Spring just prior to the Annual Clinical Assembly).
- The letter of intent to take a recertification examination must be sent to the AOBOO-HNS and be accompanied by the examination fee; letter from the AOA attesting to membership in good standing of the AOA; a copy of the diplomate's AOA record of continuing medical education for the three (3) year period preceding application; and a copy of the diplomate's current state licensure.

- The diplomate shall be required to take a written examination of the multiple choice type. This test shall be constructed to assure that by passing, the diplomate demonstrates current medical and surgical knowledge as it applies to their specialty.

Guidelines for Mandatory Recertification:

A diplomate certified by this Board with an AOA time-dated certificate may enter the recertification process within two years prior to the expiration date of the certificate. The Board will offer the recertification examination in the 8th year, allowing three (3) opportunities to pass the examination. If the diplomate passes the recertification examination prior to the 10th year, the passing grade will be held and reported to the AOA in the 10th year, which maintains the 10-year time period on certification. The new certificate issued will be valid for ten (10) years from the date of expiration of the original certificate.

- Diplomates certified in ophthalmology in 2000 and after have been issued a ten-year certificate.
- Diplomates certified in otolaryngology and/or otolaryngology/facial plastic surgery in 2002 and after have been issued a ten-year certificate.

Any diplomate who exceeds the time limit on a time-dated certification may enter the recertification process at any time, as long as the diplomate meets the "Recertification Requirements" listed below. Upon successfully completing the recertification examination, the diplomate will be issued a time-dated certificate for ten (10) years, dated from the date of the original certificate.

In the event of failure, the diplomate may reenter the examination process the following year prior to the expiration of their certificate. Upon failure of the recertification examination on the third attempt, the AOA will be notified and the certification will end. The examinee's deficiencies will be reviewed by the Board and subsequently recommend a method for remediation. Once this remediation is completed, the examinee may reenter the recertification process.

Mandatory Recertification Requirements:

- Diplomates must be in active practice, a member in good standing with the AOA and have maintained state licensure.
- Application (letter of intent) for recertification may be made anytime prior to March 31st of the year the diplomate wishes to be recertified. All materials supplied shall



remain the property of the Board. The recertification examination is administered once a year (in the Spring just prior to the Annual Clinical Assembly).

- The letter of intent to take a recertification examination must be sent to the AOBOO-HNS and be accompanied by the examination fee; letter from the AOA attesting to membership in good standing of the AOA; a copy of the diplomate's AOA record of continuing medical education for the three (3) year period preceding application; and a copy of the diplomate's current state licensure.
- The diplomate must also demonstrate eligibility for the recertification examination in any other manner prescribed by the Board.
- The diplomate shall be required to take a written examination of the multiple choice type. This test shall be constructed to assure that by passing, the diplomate demonstrates current medical and surgical knowledge as it applies to their specialty.

EXAMINATION DATES

The 2007 Board Certifying Examinations are being given at the Ritz-Carlton in Sarasota, Florida.

- Oral Exam—Tuesday, May 1st (deadline February 15th)
- Written Exam—Wednesday, May 2nd (deadline March 31st)

Contact the AOBOO-HNS Office at 800-575-2145 or email your inquiry to aoboo61040@aol.com. Additional certification information can be located at www.aoboo.org.

Report of the AAO Counsel Meeting and Surgery by Surgeons Forum By Rudy Manthei, DO

The American Academy of Ophthalmology Counsel Meeting and Surgery by Surgeons Forum was held on November 12th in Las Vegas, Nevada. After the official call to order the Surgery by Surgeons Forum began with the surgical scope update, followed by identification of the State Surgical Scope Hot Spots. Surgery by Surgeons Oklahoma activities were discussed by Doug Cox, M.D./Oklahoma State Representative and the Bill to change Oklahoma laws to reverse a rule passed by the Oklahoma Board of Examiners in Optometry that allows optometrists to perform scalpel surgery on Oklahoma patients. The rule had become law at the

end of the legislative session this May.

The last part of this session covered laser surgery/who can perform it? The American College of Surgeons created a support paper that stated that surgery using lasers, pulse light, radio frequency devices or other means is a practice of medicine and constitutes standard forms of surgical intervention. It is subject to the same regulations that govern the performance of all surgical procedures including those that are ablative or non-ablative, regardless of site of service. Patient's safety and quality of care are paramount, and the College, therefore, believes that patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. This is evidenced by comprehensive surgical training and experience, including the management of complications, and the acquisition and maintenance of credentials in both the appropriate surgical specialties, (i.e., board certification), and in the use of lasers, pulse light and radio frequency devices, or other similar techniques.

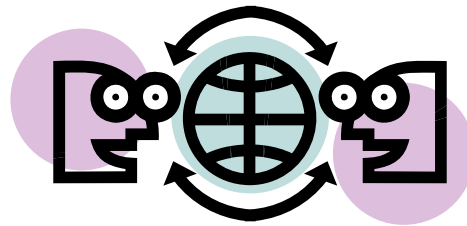
However, the College also recognizes that the use of lasers, pulse light and radio frequency devices for non-ablative treatments may be delegated to non-physicians, advanced health care practitioners. The physician may entrust the performance of non-ablative treatments through the use of written protocols, and on site supervision must be provided by the physician whenever performance of non-ablative treatment has been delegated to an advanced health practitioner. The physician is also responsible for doing the initial review of the patient and for authorizing the treatment plan, and this should be appropriately noted in the patient's chart prior to any initial non-ablative treatment.

Congressman John Sullivan; Oklahoma House of Representative, discussed and asked for support of H.R.5688. A bill to prohibit misleading and deceptive advertising or representation in the provision of health care services. This act may be cited as the (Health Care Truth and Transparency Act of 2006) which the AOCO formally endorsed at the Board meeting in September.

The Council subspecialty/specialized interest section meeting.

Speaking with one voice; Richard L. Abbott, M.D., Secretary for Quality of Care and Knowledge Based Development, reviewed the current status of the physician voluntary reporting program of the Centers for Medicine and Medicaid Services (CMS). The Preferred Practice Patterns (PPPS) and

Summary Benchmarks were used as basis for identifying measures and the Academy worked with subspecialty societies to select appropriate measures. A process of care measurement items had been proposed as a starter set. The Academy is now working with the AMA Physician Consortium to develop four to six eye care measures in 2006 for the performance measures. Dr. Abbott explained the purpose and goals for the compendium of evidence-based eye care, which will be a collection of clinical practice guidelines based on clinical evidence and expert consensus to help decision making about treating specific diseases. The successful implementation of such clinical guidelines should improve quality of care by decreasing inappropriate variation and by expediting the application of effective advances into every day practice. The purpose of the compendium is



to create a single on-line resource for the professions to obtain evidence based clinical practice guidelines to provide guidance in the management of patients. Dr.

Abbott also noted that the compendium might also be used as a template for performance measures and pay for performance and also maintenance of certification.

Maintenance of certification review course.

In July 2006 the Academy held its first MOC review course. The course material was based on the practicing ophthalmologist's curriculum (POC), the knowledge base of ophthalmic information from which the ABO derives questions for its demonstration of ophthalmic cognitive knowledge (DOC) and periodic ophthalmic review tests (PORT) examinations. The curriculum is organized by Practice Emphasis Area (PEA), i.e., subspecialty. The course was taught by 23 panel members who helped develop the POC. Eleven full day review courses were offered; ten PEAs and Core Knowledge. Everyone attended the Core Knowledge course, and each attendee had the option to attend either one or two PEA review courses of their choice. The 2007 course will be offered July 27-29 at the Westin O'Hare.

Pay for performance (P4P). The ophthalmology measures developed by the eye care group are now scheduled for final approval by the AMA physician consortium on performance improvement. Recent developments on Capital Hill related to the SGR confirmed at least a physician "pay for reporting" option tied to bonus money that would be part of a halt to the SGR cuts and could possibly go into effect as soon as mid-2007. We are working to ensure that any program is voluntary, provides ophthal-

mologists multiple mechanism for qualifying and is based on medical specialty developed criteria. To provide the broadest possible access to bonus payments for physicians, there is likely to be "a structural" measures reporting option provided, at least initially. The Academy is working with the AMA and the American College of Surgeon on such a list of 15 things that a physician could voluntarily choose three to five to attest to quality as reporting.

ASC payment reform. The expansion of covered services in ambulatory surgical centers in the proposed rule by the CMS to pay ASCs at 62% of the hospital outpatient payment system (HOPPS) rate. The Academy called for alignment between the two settings as indicated was the goal of the rule, as well as for a rate that takes into account savings of the shift from outpatient setting to ASCs and allows patients to make true comparisons based on cost and quality.

General session. Credentials committee report/requires 85% of the voting membership of the AOCO to be members in the AAO. If this percentage falls below we will lose our seat on the Council.

The AMA has formed a scope of practice partnership, SOPP.

Federal affairs update. The five year review work RVUs. The final rule adopts the Relative Value Update Committee's recommendation that increase the work component for RVUs for face to face visits, for example, the work component for RVUs associated with an intermediate office is increasing 37%. Despite objections by the medical community, CMS is applying the Budget Neutrality (BN) factor to the work RVUs. The work RVUs will be reduced by approximately 10%. CMS argues they are applying the budget neutrality to the work RVUs will not reverse the improved accuracy of the values that have been assigned to the E&M services, nor would it distort the relativity of the RVUs. Realizing that other payers use the fee schedule rates, CMS is publishing the RVUs without the BN adjustment. Also in the five year review 11 ophthalmology codes were increased, while 11 ophthalmology codes were decreased and there was no change in the two others. There will be a 2% decrease with the WRVU for cataracts, while there will be a slight increase in YAG capsulotomies. E/M codes increased for most 99201 through 99251. 2007 expect cataract reimbursements to decrease by 11%.

In 2007, there will be a decrease of 2% of the WRVUs and a 1% decrease in the PERVU (practice expense) and a 5% decrease due to the SGR leading to a cumulative 8% reduction for ophthalmology. Expect an additional 6% of WRVU and PERVU on top of the SGR by 2010. Compared to other specialists they will receive a 6% decrease versus ophthalmology's 8% decrease in 2007.

It is time to get involved!!!

AAO Newsroom Vision Loss Can Be Prevented in People with Diabetes

Researchers on Verge of Developing New Pharmacological Treatments

The millions of Americans afflicted with Type 1 and 2 Diabetes face many potential complications, including: heart and kidney disease; nerve damage and stroke; foot and skin problems; and gastrointestinal disorders and hypoglycemia.



Another major complication, affecting up to 24,000 new people per year, is permanent blindness due to diabetic retinopathy, a degenerative disease of the retina (the sensitive area at the back of the eye). Overall, diabetic retinopathy affects 5.3 million Americans 18 and older.

But there's hope. In observance of Diabetic Eye Disease Awareness Month (November), the American Academy of Ophthalmology wants Americans to know that even though diabetes is the leading cause of new cases of blindness, vision loss can be prevented if the disease is diagnosed and treated in time.

"Only 50 to 60 percent of those with diabetes get the recommended yearly eye examinations," says Jose S. Pulido, MD, Academy clinical correspondent and professor of ophthalmology at the Mayo Clinic in Rochester, MN. "Studies show effective treatments, including an annual dilated eye exam, can reduce severe vision loss by up to 94 percent."

According to the American Diabetes Association, there are 20.8 million people in the United States, or 7 percent of the population, who have diabetes. While an estimated 14.6 million have been diagnosed, 6.2 million people (or nearly one-third) are unaware that they have the disease.

"This is a tragedy waiting to happen because people who are unaware they have

the disease are at a substantially greater risk for vision loss and other complications," said Dr. Pulido. "The first step in preventing complications is finding out if you have the disease. It's important for all healthy adults over the age of 45 to have a blood sugar test once every three years."

Dr. Pulido said that the longer a person has diabetes, the greater the risk for developing diabetic retinopathy.

"Diabetic retinopathy does not only affect people who have had diabetes for many years, it can also appear within the first year or two after the onset of the disease," he said. "For some people, diabetic retinopathy is one of the first signs of the disease."

ANATOMY OF DIABETIC RETINOPATHY

High blood sugar levels weaken blood vessels in the eye's retina, causing them to leak blood or fluid. This causes the retina to swell and can lead to vision loss.

Blood sugar fluctuations can also promote growth of new, fragile blood vessels on the retina, which can easily break and leak blood into the vitreous (the clear, jelly-like substance that fills the center of the eye). This can blur vision and lead to permanent blindness.

In its earliest stages diabetic retinopathy may not affect vision, but over time it can cause vision loss and even blindness in both eyes.

WHAT ARE THE SIGNS OF DIABETIC RETINOPATHY?

"Fluctuations in blood sugar levels can temporarily affect vision, so it's sometimes difficult to know if a serious eye problem is developing," said Dr. Pulido. "That's one of the reasons strict control of your blood sugar is so important. If you notice a vision change in one eye, a change that lasts more than a day or two, or changes not associated with fluctuations in blood sugar, contact your ophthalmologist immediately."

Other ways to reduce the risk of eye disease:

- Keep your blood glucose level as close to normal as possible through diet, exercise and, if needed, medication
- Keep your blood pressure under control
- Keep your cholesterol levels low
- Don't smoke
- Make sure your hemoglobin A1c levels (a measure of good blood sugar control) are measured at least every four months and are less than 7.1.

DIABETIC RETINOPATHY: A NEW HOPE

Although incurable, diabetic retinopathy can be treated to retard its onset and progression. There's hope for the development of new pharmacological treatments that would not require invasive laser surgery. These treatments might

even restore the vision that the disease destroys.

These potential treatments signal a move away from laser photocoagulation to drugs injected into the eye, as well as oral treatments.

Many of these drugs block the pathways that contribute to the vascular disruptions that characterize diabetic retinopathy. Specifically, they aim to inhibit the growth of new blood vessels or the activity of proteins in the nerve cells of the retina.

These treatments hold promise of intervention at earlier, non-sight-threatening stages, but they will require renewed emphasis on early detection. The newest and best treatments will be most effective only when the underlying disease—diabetes—is under control.

FREE EYE EXAMS FOR SENIORS

EyeCare America, a public service foundation of the American Academy of Ophthalmology encourages diabetes patients, age 65 and older, to take advantage of its Diabetes EyeCare Program. This year-round program offers eye exams and up to one year of care at no out-of-pocket cost to qualified patients who are without an ophthalmologist.

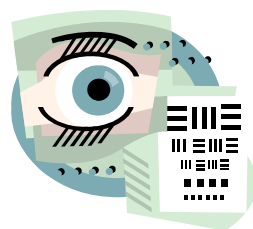
To see if someone you know might be eligible to receive a referral to one of EyeCare America's 7,300 volunteer ophthalmologists, call 1-800-272-3937. The EyeCare America help lines are open 24 hours a day, every day, year round. More information on EyeCare America can be found at www.eyecareamerica.org.

AAO Joint Meeting Recap Head of Google's Philanthropic Arm says Ophthalmology is Uniquely Poised to Take Advantage of the "new philanthropy"

He should know. As executive director of Google's philanthropic arm and founder of the Seva Foundation, Lawrence Brilliant, MD, is the very embodiment of the new philanthropy. Google has given him an estimated \$1 billion and asked him to apply his innovative vision to solve the largest of the world's problems. Dr. Brilliant and

Alfred Sommer, MD, who identified the role of vitamin A deficiency in childhood blindness, were featured speakers at the Opening Session at the Joint Meeting in Las Vegas in November.

Dr. Brilliant explained that the old philanthropy focuses simply on doling out grants. Old philanthropy builds the small clinic in a poor country. It may be noble work, but it's not financially self-sustainable or scalable, and it tends to build dependency. New philanthropy thinks of its work as an investment. It applies market focuses to maximize its investment, controls costs and closely monitors outcomes. Most importantly, it is scalable. "The new philanthropy asks: 'Is it globally sustainable, is there an exit strategy for the donors, is it profitable, socially good and environmentally stable?'" It always asks before writing the check, "Will this change the world?" Dr. Brilliant said. "It's a great adventure to make the world better for our children and grandchildren."



So how does ophthalmology make its efforts in blindness prevention attractive to the new philanthropy? Dr. Brilliant has some advice: Focus on

providing excellent service, keep costs down, watch margins, track outcomes, use automated patient and financial records, use the Web for diagnosis and think outside the box.

"Technology is not just lasers," he said. "Aravind (Aravind Eye Care System in India) has mobile eye vans that diagnose, triage and provide transportation all in one."

Ophthalmology will be able to take advantage of the new philanthropy, he said, because it is a profession that "has made prevention and international work a part of its DNA."

Evidence of this DNA became immediately apparent after Dr. Brilliant told the audience that these ideas would be explained further at an International Forum immediately following the Opening Session—200 ophthalmologists got up and followed him to the forum, where they were treated to examples of the new philosophy in action today. They heard from Susan Lewallen, MD, who has helped build a clinic in Tanzania where she trains cataract surgeons who go out to villages to perform cataract surgery. They also heard from David Green, founder and executive director of Project Impact, a nonprofit organization dedicated to making medical technology and medical services accessible, affordable and financially self-sustaining. Mr. Green is one of the "adventure capitalists" Dr. Brilliant

described in his presentation. Project Impact, through a collaboration with AuroLab, helped bring to market a novel, foldable IOL that costs only \$10. "You (the ophthalmologist) can access the new philanthropy," said Dr. Brilliant. "Paying patients can fund the growth of sustainable systems. We can give the right to sight for every person. The question is, 'Who's going to pay for it?'"

Conductive Keratoplasty Appears a Good Alternative for Post-LASIK Patients

During Refractive Surgery Subspecialty Day program, Michael Gordon, MD, reported results from a prospective, multicenter clinical trial of conductive keratoplasty on emmetropic patients who underwent previous myopic LASIK. In this study 44 patients (44 eyes) with a mean age of 53 years, had CK with eight spots at the 8mm optical zone in the no dominant eye to improve near vision. Mean years between LASIK and CK was 5.3 years. At three months postop, 88 percent had a near UCVA of J2 or better and 95 percent had J3 or better. At six months, 78 percent had near UCVA of J2 or better and 87 percent had J3 or better. In terms of predictability, 78 percent were with 0.5 D of target. No eye lost two or more lines of BCVA-distance. No eye had a BCVA-distance worse than 20/40 or had an increase of more than 2 D of cylinder. Also, 86 percent had 20/20 or better intermediate vision and all eyes had 20/32 or better. More importantly, this procedure made for very happy patients: 91 percent reported a significant or moderate improvement in vision, and 91 percent reported being very satisfied to satisfied with their vision. "This is a very appealing procedure for post-LASIK patients because of the safety and simplicity of the procedure," Dr. Gordon said. "And because these patients are motivated to remain glasses free."

Wavefront-guided Surface Ablation with MMC can Successfully Salvage LASIK Flap Complications

Maria Regina Chalita, MD, reported on three patients whose surgery was aborted following complications of buttonhole or

irregular flaps. She spoke during Refractive Surgery Subspecialty Day. Three to four months later, all patients underwent wavefront-guided PRK with MMC. After the LASIK complication, all eyes lost at least one line of BCVA. After PRK, all eyes returned to their preoperative BCVA, and high-order aberrations were reduced in all cases. Dr. Chalita cautioned that epithelial removal should be gentle in order to avoid flap complications or epithelial ingrowth. No patient experienced delayed epithelial healing or side effects. No MMC related complications were noted.

Punching It Out Under Pressure

Surprise! The question of how best to manage glaucoma progression was posed at the Glaucoma Subspecialty Day, and boxing gloves were passed around to several panelists.

The first round of collegial sparring began with Dale K. Heuer, MD, squaring off with Jody R. Piltz-Seymour, MD, on the question of whether surgery is indicated in the presence of glaucoma progression and a mean IOP of 10 mmHg. "Cut away!" was the answer from Dr. Heuer, who noted that if the standard deviation is considered, a mean pressure of 10 mmHg necessarily ignores the higher pressures within the deviation. In fact, he pointed out, peak pressures often occur outside office hours, thus eluding detection. He pointed to a study by Medeiros and colleagues that found that POAG patients on medication had pressure fluctuations greater than those who had trabeculectomy. Another study by Konstas and colleagues showed that surgery achieves lower pressures longer than medication. "Not so fast!" was Dr. Piltz-Seymour's response, on the grounds that, in OHTS at least, 86 percent of visual field deficits are not confirmed on repeat testing, and there is a multitude of risk factors not addressed by surgery, such as autoimmunity, sleep apnea and systemic hypertension. In addition, there is little evidence that lowering IOP below 10 mmHg is useful. In any event, she added, medical management is far safer than surgery. In their final round, Dr. Heuer sang his rebuttal, and Dr. Piltz-Seymour delivered hers in rhyming verse.

The next exciting match pitted Richard Parrish, MD, against challenger Kuldev Singh, MD, on the question of whether selecting a target IOP is necessary for effective glaucoma management. Dr. Parrish took what might be considered the mainstream view: Virtually every study and anecdotal report shows that clinicians who choose a target pressure consistently arrive at lower pressures than those who do not. Wait just a minute, said Dr. Singh. Intraocular pressure has been dethroned

as the sole criterion for glaucomatous damage, and the fabled pressure of 12 mmHg is just simply arbitrary when considered in the context of the many contributing factors for progression. Apparent disc changes may or may not be related to true visual loss, and what makes more sense is to target the range of pressure that each patient can tolerate without progressing, said Dr. Singh.

The Itching, Burning Eye: Diagnostic Algorithm and Management Options

*By Srinivas Rao, DO, Surendra Basti, MD, Amy Lim, MD, Geetha Iyer, DO, G. Seethalakshmi, DO, Dennis Lam, MD**

(Reprinted from www.medscape.com/viewarticle/547387)

Abstract

The healthy ocular surface is a complex, composite unit that is essential for patient comfort and visual function. A number of components need to work in an integrated manner to ensure that this is achieved, and a variety of causes can result in the final common symptom complex that can be termed the *itching, burning eye*. Many of these causes may be due to relatively common and simple issues related to lid disease, allergies, tear dysfunction, excessive computer use, exposure to polluted environment, and convergence problems. However, a smaller group may have potentially more serious pathology due to causes such as underlying immune dysfunction, or tumors; rarely, intraocular conditions and some neurological causes may present with ocular redness and grittiness. Failure or delay in the diagnosis of these latter entities can result in significant morbidity to the eye. This article will clarify issues related to the functioning of the ocular surface, provide a diagnostic algorithm for managing these patients, and discuss the current knowledge in the management of these conditions once they are diagnosed. It is targeted at the practicing ophthalmologist and should help him or her to manage this problem effectively.



Introduction

The ocular surface is a complex biological continuum, and it is a composite of several interdependent structures. Constant interaction between the components with continuous feedback from environmental, endocrinological, and cortical factors results in a highly dynamic system. This complex interplay between a multitude of different factors produces a delicate homeostasis that can be disturbed by a number of influences: the ocular environment, systemic factors, physical environment, and medications. As the eye is capable of only a limited number of responses to these diverse insults, which often manifest as itching or a burning sensation, it is sometimes difficult to arrive at an accurate etiological diagnosis based on patient symptomatology alone. The purpose of this article is to describe the various conditions that can lead to this complex symptom, and outline and algorithmic approach for precise etiological diagnosis to facilitate appropriate management.

The constituents of the tear film are produced by the main and accessory lacrimal glands, the mucus secreting goblet cells, and the meibomean glands in the lids. Their secretion is controlled by interconnecting autonomic and sensory nerves in response to stimuli from the ocular surface, normal innervation of which is therefore vital for a healthy tear film. Normal spreading of the tear film over the structures of the ocular surface is facilitated by the blinking action of the lids, which also serves as a pump for drainage of tears into the nasolacrimal system. These structures therefore constitute the lacrimal functional unit, the function of which is to maintain corneal health and clarity.

The lids provide a mobile mucosal lining that covers the entire ocular surface, and they constitute the first line of defense of the ocular surface against dehydration, trauma, and exposure to allergens. Although the eyelid skin is unique because it contains no subcutaneous fat and it is the thinnest skin in the body, it is otherwise similar to skin elsewhere in the body and is susceptible to similar insults. Desquamating disorders, allergies, viral infections, and tumors can affect this structure, but in addition to the lid changes that can result, these conditions often produce significant adverse effects on the ocular surface as well. In addition to these extrinsic conditions, various problems in the constituents of the lids, especially the lashes and the meibomean glands, can result in significant ocular morbidity. The orbicularis oculi muscle is responsible for proper lid closure and adequate blinking. Dysfunction due to neurological disorders or myopathies can result in

lagophthalmos and inadequate blink, which leads to chronic ocular surface exposure. Prolonged ptosis or drooping of the lid, especially in patients who are moribund or comatose, can result in inadequate surfacing of the corneal surface by the blink reflex, and this can sometimes produce extensive, recalcitrant filaments on the cornea—a profoundly distressing condition. The tarsal plate forms the fibrous skeleton of the upper and the lower eyelid, and is required for maintaining the anatomical integrity of the lids. Disorders that produce distortion of the tarsal framework result in suboptimal apposition of the lid to the ocular surface. Misdirected lashes and lid margins can also have deleterious effects on the health of the ocular surface.

The conjunctiva is the thin translucent mucus membrane covering of the eye. Histologically, the conjunctiva is composed of stratified columnar or cuboidal nonkeratinized epithelium. The goblet cells that produce mucin are found interspersed in the epithelium (constituting 5-10%) and are present in largest numbers in the inferonasal bulbar and tarsal conjunctiva. In addition to its role in tear function, the conjunctiva is also the seat of the highly specialized immune defense of the ocular surface. It is generally believed that the conjunctival stem cells are located in the fornix where they are well protected from environmental insults. Irritative stimuli to the ocular surface lead to an increase in mucin production. This is a protective response that helps to coat the offending agent and reduce surface damage, and subsides once the stimulus is removed (as in a foreign body, a poorly machined ocular prosthesis, or an exposed retinal buckle element). A chronic inflammatory insult, however, results in squamous metaplasia, a process characterized by the development of keratinization and loss of goblet cells with decreased mucus production. If the stimulus persists, a vicious cycle of inflammation and metaplasia is set up, which can lead to permanent destruction of the ocular surface. In allergic conditions, the mast cells present in the substantia propria of the conjunctiva play an important role in potentiating the ocular changes by releasing histamine and other inflammatory mediators. Eosinophil chemotaxis further accentuates the damage, as they can release epitheliotoxic substances, such as major basic protein and eosinophil cationic protein.

The maintenance of a normal tear film depends on the presence of a normal ocular surface epithelium and vice versa, reinforcing the concept of a dynamic integration of the various units of the ocular surface. The traditional view of a three-layered tear film structure proposed by Wolff is now being replaced by the concept

of a mucin aqueous gel decreasing in density toward the lipid layer. Important functions of a healthy tear film include the following: providing a smooth and regular optical surface, lubrication, flushing action, corneal nutrition, defense against infection, maintenance of epithelial cell health, and protection from environmental and infectious insults. Functioning primarily as a surfactant, the mucin layer secreted by conjunctival goblet cells and corneal epithelial cells converts the hydrophobic epithelium into a hydrophilic surface and allows the aqueous to spread evenly over the surface. By virtue of its non-Newtonian properties, it decreases the shear force exerted on the ocular surface with every blink to negligible levels. Loss of the mucin layer leads to shearing of the epithelial cells, with resultant ocular surface irritation and inflammation. The aqueous layer is primarily responsible for providing a trophic and protective environment for the ocular surface. Growth factors maintain the health of the ocular surface, while immunoglobulins and other proteins protect from infection by bacteria and viruses. The electrolytes in the tear film are responsible for maintaining tear film osmolarity, which, in turn, is responsible for maintaining cellular homeostasis. The normal volume of the tear fluid averages about 7 μ l, with an average tear flow rate of 1.2 μ l per minute, and the osmolarity averages 302 mosm/L. Aqueous tear deficiency leads to a hyperosmolar tear film, which is toxic to the conjunctival epithelium, both by a direct osmotic mechanism and by mediated inflammatory activity. The lipid layer of the tear film is composed of polar and nonpolar lipids, and is secreted by the tarsal meibomian glands. Its primary function is to retard evaporation of aqueous tears, prevent overflow of the tears, and reduce disruption of the tear film by skin fatty acids.

A complex of sensory, sympathetic, and parasympathetic nerves links the components of the lacrimal functional unit into a homeostatic loop in order to protect and support the ocular surface. Tear secretion from the lacrimal functional unit is controlled by stimulation of the afferent sensory nerves from the ocular surface. In the normal state, subthreshold sensory input from the ocular surface modulates secretory activity via the efferent sympathetic and parasympathetic innervation of the lacrimal and meibomian glands. The heightened sensation seen in punctate corneal epitheliopathy due to tear breakdown is probably due to disruption of the tight junctions in the apical cell layer of the epithelium, which allows greater access of environmental stimuli to the sensory nerve endings.

The coordinated functioning of the ocular surface is directed primarily toward maintaining an optically clear corneal

surface, the prerequisite for vision. Stromal hydration, the other important factor in maintaining the optical transparency of the cornea, is of course a function of the corneal endothelium. The corneal epithelium is five to seven layers in thickness. The apical layer has microvilli, which help to anchor the tear film. The intact and functional tear film helps regulate epithelial cell exfoliation, which is disturbed in the case of tear deficiency. The barrier function of the epithelium is in part due to the mucin and glycocalyx coating over the epithelium in addition to the tight junctions. The corneal stem cells located at the limbus are responsible for renewal of the epithelial cells and maintenance of corneal clarity. Any damage to the limbal stem cells results in corneal epithelial breakdown and stromal vascularization, ultimately leading to conjunctivalization with poor comfort and function.

Symptomatology

The prevalence of dry eye in the general population is still not known precisely. The reported prevalence varies widely, possibly due to the varying criteria used to define the condition in different studies and variations in the study populations. Dry eye, however, has a substantial impact on the quality of life, including decreased productivity at work. Ocular allergy is a common hypersensitivity disorder that affects 15-20% of the population in developed nations. Both ocular allergy and dry eye are extremely common in the population and represent a significant proportion of the patients seen in the ophthalmologist's office. With these conditions, as with other problems affecting the ocular surface, the patient presents with symptoms of redness, itching, and burning of the eyes. This group of symptoms is not specific for any group of ocular disorders. Inappropriate treatment of the underlying disorder can sometimes exacerbate the condition, worsening both comfort and ocular surface changes. An accurate diagnosis is facilitated by thorough history-taking and a detailed examination of patients with these "itching, burning eyes."

Approach to a Patient with Itching, Burning Eyes

History-taking is an integral part of the ocular examination in dry eye and allergic states and often helps in revealing associated conditions that could aggravate the ocular problem. Most types of dry eye are more common in women, especially in the postmenopausal state, possibly due to hormonal changes. Diseases with a poor prognosis, such as Stevens-Johnson syndrome (associated tear dysfunction), usually have an abrupt onset of signs and symptoms. Leading questions help

ascertain if the condition has progressed since inception. Dry eye states with an underlying immune disorder generally tend to progress relentlessly, while others, such as ocular cicatricial pemphigoid, have a characteristic chronic recurrent pattern. Allergic disorders tend to have a seasonal exacerbation, particularly during spring when grasses and tree pollen are common. The presence of a stringy discharge is also frequently described by the patient, indicating an allergic diathesis. Any treatment that the patient has received in the past should be noted in addition to the perceived response of the patient to the prescribed medications.

Tearing, although commonly seen in allergic disorders, can also be associated with dry eye states. This seemingly paradoxical response is due to the reflex tearing initiated by increased stimulation from the drying ocular surface. The diurnal periodicity of the symptoms should also be noted. Patients with moderate dry eye tend to have more symptoms as the day progresses due to increased evaporation during the day. In patients with immune-related dry eye, the lacrimal gland functioning is subnormal on awakening. On the contrary, patients who complain of symptoms primarily in the evening tend to have meibomian gland inflammation that causes progressive contamination and dysfunction of the tear film. The occupational environment of the patient is important, and conditions that increase evaporation from the ocular surface (such as constant exposure to a low-humidity, air-conditioned environment; extremely hot and dry surroundings; or to dust or chemical fumes) should be noted. A number of drugs could aggravate the dry eye state. A few of these include antitussives, antihypertensives, antihistamines, decongestants, and antidepressants. A number of systemic diseases can be responsible for or aggravate the dry eye state. Rheumatoid arthritis is one of the common associations of dry eye, and a history of morning joint stiffness should be determined. Immune dysfunctional states can alter the other secretory glands, resulting in dry mouth and/or poor oral hygiene. Meibomian dysfunction due to seborrheic dermatitis (dandruff) is a common cause of tear film alteration. Allergic disorders may be associated with rhinitis, eczema, and other conditions, such as hay fever, asthma, and urticaria, either in the patient or in relatives of the patient.

Importance of Rapport-Building

Although history-taking primarily serves to try to detect the presence and severity of, as well as the associated risk factors for an itching, burning eye, it has another important purpose. Both dry eye and ocular allergy are relatively chronic conditions for

which there is no specific cure. As the disorders also have an important psychological component, it is vital for the patient to develop trust and confidence in the treating physician. The history-taking process is a good opportunity for the clinician to develop a rapport with the patient. This process also helps the physician assess the profile of the patient, his or her expectations from the treatment, and his or her understanding of the disease process. It is extremely important for the patient to clearly understand the nature of the disease at the outset, as well as the scope of the treatment and the symptom relief that is possible.

Examination

After taking a detailed history, the physical examination should be performed in a meticulous manner in an effort to discern the cause of the patient's symptoms. Special attention should be paid to the external examination, which should include a "zoomed-out" naked-eye view of the patient, with diffuse illumination. Observation of the blink rate is important; low blink rates are common in patients with neurotrophic corneas, as well as in monocular patients and may contribute to a dry eye. A rosy complexion and/or telangiectasia over the nose, cheeks, and glabellar areas may suggest rosacea, which can adversely affect the lids and cornea. Rosacea can easily be missed in pigmented races and needs to be specifically looked for. Grossly scaly, erythematous eyelid skin may suggest atopic or contact dermatitis, or eczema. Lid edema would suggest an allergic cause. The presence of lagophthalmos would point to exposure keratitis. Unilateral or bilateral proptosis or scleral show would suggest thyroid ophthalmopathy, another cause of exposure. Ulnar deviation or "swan-neck" deformities of the hand and finger joints would suggest rheumatoid arthritis.

Preauricular nodes are enlarged in patients with viral conjunctivitis. Enlarged salivary glands are seen in some autoimmune diseases, such as rheumatoid arthritis. Excess lid or canthal tendon laxity may cause poor tear distribution, causing irritation and dry eyes. An extreme example would be floppy eyelid syndrome, which can cause irritation during sleep and on awakening, as the patient often sleeps in a face-down position. This condition can be ascertained by elevating the eyelid skin just under the lateral third of the eyebrow. The eyelid everts with such a maneuver in patients with floppy eyelids.

Slit-lamp biomicroscopy should focus on the anterior eyelid margin, eyelashes, posterior eyelid margin, tear film, tarsal and bulbar conjunctiva, cornea, and anterior chamber. Entropion and ectropion are common causes of irritation from the lids

and lashes. Collarettes and/or crusts over the eyelashes and hordeola are suggestive of anterior blepharitis. Telangiectatic blood vessels and thick secretions seen along the meibomian gland orifices or expressed with gentle pressure on the eyelid margin, and recurrent chalazia can indicate posterior blepharitis. Lid margin lesions cause eye irritation; a good example of this is chronic conjunctivitis secondary to an umbilicated lesion on the lid margin secondary to molluscum contagiosum, or a wart of viral etiology.

Careful examination of the tear film and external ocular surface is a critical component of the effort to unravel the possible cause of an itching, burning eye. A decreased tear meniscus and the presence of debris in the tear film suggest aqueous tear deficiency. An excessive tear meniscus with conjunctival surface inflammation can be seen in eyes with tear stasis. These eyes tend to have a functional block of the tear drainage pathways, and syringing reveals patent lacrimal pathways. If surface inflammation persists, the use of topical steroid eye drops can relieve the functional block, improve tear stasis, and relieve patient symptoms. Thicker secretions would be suggestive of viral conjunctivitis. Mucoïd, stringy secretions are seen in allergic conjunctivitis.

Next, the bulbar and palpebral conjunctiva should be inspected. Sectoral erythema on the bulbar conjunctiva could suggest episcleritis, scleritis, or superior limbic keratoconjunctivitis (SLK). Papillae on the palpebral conjunctiva and chemosis of the bulbar conjunctiva are suggestive of allergic conjunctivitis. Large papillae under the upper eyelid suggest the possibility of giant papillary conjunctivitis (GPC) or vernal conjunctivitis. Trantas dots at the limbus would be suggestive of limbal-vernial conjunctivitis. One reliable sign of an allergic etiology is the presence of pigmentation in the conjunctiva, especially in the perilimbal region. This sign is present in pigmented individuals and may be less prominent in fair-skinned individuals with allergic conjunctivitis. The presence of conjunctival follicles could suggest adenoviral conjunctivitis, a toxic reaction, chlamydial or herpes simplex infection, or molluscum contagiosum in the periocular skin. The examiner needs to look out for small foreign bodies as well. Pseudomembranes strongly indicate adenoviral conjunctivitis, but can also occur in primary herpes simplex infections and chlamydial conjunctivitis. Scarring of the conjunctiva could be suggestive of autoimmune cicatrizing conjunctivitis, such as ocular cicatricial pemphigoid, pseudopemphigoid, or Stevens-Johnson syndrome. Other causes for cicatrization are recurrent infections, adenoviral conjunctivitis, alkali burns, or trachoma.

Signs such as forniceal foreshortening, keratinization of the caruncle, and symblepharon are more common in autoimmune cicatrizing conjunctivitis. Excessively lax conjunctiva can be seen in elderly patients and is characterized by loose folds of conjunctival tissue that involve the inferior and interpalpebral bulbar conjunctiva. These folds are accentuated during lid closure, cause irritating symptoms, and interfere with tear function. Raised lesions, such as a cyst, pterygium, phlyctenule, or pyogenic granuloma, may also cause localized inflammation and/or irritation.

The cornea should be examined carefully for infiltrates, lesions, abnormal vascularization, and thinning. For example, well-defined subepithelial infiltrates in the periphery would suggest staphylococcal marginal keratitis. Raised grey-white subepithelial lesions could suggest Salzmann nodular degeneration. Punctate subepithelial infiltrates and vascular pannus are suggestive of contact lens overwear. A grey-white lesion with surrounding infiltrate and vessels from the limbus could suggest a corneal phlyctenule. An area of thinning could be suggestive of a rheumatoid melt, or dellen, if adjacent to an elevated lesion. An active keratitis may be characterized by infiltrates with surrounding haze or dendrites, and possibly an anterior chamber reaction. The presence of filaments, which are fine strands of degenerated epithelial cells and mucous adherent to the cornea most commonly represent dry eye syndromes, but may also occur with prolonged patching, a foreign body, or superior limbic keratoconjunctivitis.

Further testing can be performed as part of the examination or as part of a systemic workup, depending on the findings elicited by history and discerned by the ocular examination.

The entire article is available at <http://www.medscape.com/viewarticle/547387>

*Drs. Rao and Lam are affiliated with the Department of Ophthalmology and Visual Sciences, The Chinese University of Hong Kong. Drs. Basti and Lin are affiliated with the Department of Ophthalmology, Northwestern University. Drs. Iyer and Seethalakshmi are affiliated with Cornea Services, Tamil Nadu, India. Disclosure: The authors reported no proprietary or commercial interest in any product mentioned or concept discussed in this update.

AOA News



AMERICAN OSTEOPATHIC ASSOCIATION

LECOM Named to the First President's Higher Education Community Service Honor Roll

Lake Erie College of Osteopathic Medicine (LECOM) Bradenton and Erie campuses were named to the first President's Higher Education Community Service Honor Roll for distinguished community service in recognition of the school and its osteopathic medical students' exceptional community service over the past year, contributing their time, resources, energy, skills — and intellect — to serve America.

"LECOM medical students in Erie, Pa., earned more than 22,000 TOUCH Point hours last year performing community service. LECOM-Bradenton, in Florida, and the pharmacy school provided thousands of additional hours working with children, senior citizens and local residents," explained Pierre Bellicini, LECOM Director of Communications and Marketing.

TOUCH Point, or Translating Osteopathic Understanding into Community Health, is a program that all osteopathic medical campuses are asked to participate in as part of the Student Osteopathic Medical Association.

LECOM and 140 other institutions of higher education were recognized for distinguished service among the nearly 500 schools named to the President's Honor Roll at the Campus Compact 20th Anniversary. This two-day event in Chicago was held to celebrate the 20th anniversary of Campus Compact, a coalition of more than 1,000 college and university presidents — representing some 5 million students — who are committed to building civic engagement into campus and academic life.

Among the many community projects lead by LECOM, much of the efforts were in response to the devastation remaining from Hurricane Katrina. LECOM-Bradenton organized a 10-person committee of osteopathic medical students, faculty and staff to raise funds and supplies to benefit the hurricane victims. Between September 2005 and January 2006, the student body collected clothing, food,

school supplies, and funds to send to the residents of a LECOM-Bradenton student's Mississippi hometown.

Additional fundraising as well as clothing and food drives were held throughout September and October, eventually raising \$1,000 to send a delegation of four students with the Student Osteopathic Medical Association's (SOMA) Unity project to Long Beach, Miss.

In addition to these Hurricane Katrina efforts, 12 LECOM-Bradenton students received disaster relief training to staff the Manatee Technical Institute, an elementary school which would serve as a disaster shelter for handicapped persons in the event of a hurricane directly hitting the Sarasota/Bradenton Florida area.

Created after the devastating Southeast Asia tsunami, the LECOM Cares program's purpose is to supply financial aid and medical supplies after any disaster. After Hurricane Katrina hit, LECOM –Bradenton students went into action to raise another \$3,000 in cash plus nearly \$2,000 in medical supplies within a few days of the storm. In Erie, students raised \$5,000 in cash and \$1,800 in clothing and medical supplies to help the hurricane victims.

"We're proud that LECOM students enthusiastically adopt the osteopathic principles of compassion and caring for the community. At LECOM, we believe that the community is our campus," says Bellicini.

LOMA Hosts an Inaugural CME Conference

The Louisiana Osteopathic Medical Association (LOMA) recently hosted its first continuing medical education (CME) conference. The Inaugural CME Conference was held at the Hilton Garden Inn/Cajundome in Lafayette, La., November 3-5, 2006.

Of the 40 participants, attendees included DOs, osteopathic medical students, registered nurse practitioners and paramedics.

"We had DOs from Louisiana, Mississippi, and Texas," explained Ed Williams, the executive director of LOMA. "It was an excellent first event with quality presentations."

Ray Stowers, DO, a member of the AOA Board of Trustees and Dean of Lincoln Memorial University DeBusk College of Osteopathic Medicine in Harrogate, Tenn., presented an AOA Update. Also in attendance was Mark Dawson, MD, a member of the Louisiana State Board of Medical Examiners, who has worked diligently with the AOA and

local osteopathic physicians for many years to achieve parity in licensing for DOs in Louisiana. Dr. Dawson was recognized for his contributions to the osteopathic profession in the state.

The program, titled "Focus on Primary Care" was approved for 26 hours of AOA CME credit. Speakers from Louisiana, Florida, Mississippi, New York and Utah lectured on topics ranging from asthma throughout pregnancy and children with asthma to treating geriatric patients with OMT.

Among the obstacles that presented themselves in the first CME conference, Williams mentioned the lack of historical background was among the hardest to overcome. Every piece of the conference had to be created from scratch and the lack of experience and interaction with LOMA made many potential participants sluggish to register. However, he is hopeful that the success of this conference will serve as a beacon for the profession and have positive impact on future conference registrations and LOMA recruitment.

Due to the financial constraints of a small membership and a short history, Williams was forced to be innovative in his search for funding the event while insuring its quality. In addition to some speakers waiving their traditional honoraria; LOMA received a small operational loan from the AOA through the Division of Affiliate Affairs; an AOA OPP/OMT Grant funded by the Dale Dodson Educational Fund; and an Osteoporosis grant from the AOA's Division of Quality Programs and Public Health funded by unrestricted educational grants from Roche and GlaxoSmithKline. Outcomes Management Educational Workshops, a group that provides CME workshops at no charge, also presented three workshops at the meeting.

Help for LOMA also came in the form of expert guidance from colleagues at the AOA and in other states. Williams highlighted the training and direct assistance; examples of forms and procedures; and speaker recommendations as extremely helpful advice from members of the Association of Osteopathic State Executive Directors.

"I am particularly indebted to Jeffrey LeBoeuf and his Mississippi Osteopathic Medical Association staff who have adopted LOMA and provided me with much assistance and training."

The successful outcome of Williams' hard work and the help of many others was duly noted by one visiting osteopathic physician from Texas, who described the LOMA conference as the best CME event he had been to in years.

OMT Grants are Available

Osteopathic state and specialty associations can continue to help DOs maintain their distinctiveness through the AOA OPP/OMT Grant Program. Thanks to the generous support of the Dale Dodson Educational Fund over the past six years, more than 65 osteopathic state and specialty organizations were able to conduct OMT programs and workshops, continuing to teach DOs the value of osteopathic manipulative treatment.

In addition to OMT lectures/workshops, the AOA encourages osteopathic state and specialty organizations to expand the use of the grant beyond just CME programs by holding OMT demonstrations for the media or the public to help educate others about DOs and osteopathic medicine.

Grants are available now through the end of the AOA's fiscal year (May 31, 2007) or until funds run out.

The requirements for submitting an application include:

- Grants are limited to osteopathic state and specialty organizations with fewer than 400 active DO members.
- Funding is limited to \$2,000 per grant request.
- Eligible organizations may only receive one OMT Grant per AOA fiscal year (June 1, 2006 - May 31, 2007).
- Recognition of the Dale Dodson Educational Fund and AOA in all event materials as program sponsors is required.
- Administrative costs such as copies, postage and AV equipment or room rental will not be considered for grant funding

Applications can be found inside the members-only portal on DO-Online within the Affiliate Section, under AOSD resources. Requests for applications, completed applications or questions can be directed to Mary Ann Rausa, AOA Assistant Director of Communications, at 1-800-621-1773, x. 8040 or via email at mrausa@osteopathic.org.

It's never too early to start thinking about projects that could be funded through the AOA's OPP/OMT Grant Program. So, don't waste another second—submit an application today!

OPAN Gets an AOA Overhaul

The *OPAN* (osteopathic public awareness network) *electronic newsletter* will be redesigned in 2007. The new look will embody the AOA brand while guaranteeing the continued delivery of highly valuable content. The changes will make it easy for

readers to find the news they need and to quickly recognize the newsletter as a product of the AOA.

In addition, a link to OPAN will be incorporated into Touch Points—the AOA's official monthly electronic newsletter which also receives a new look beginning in January 2007.

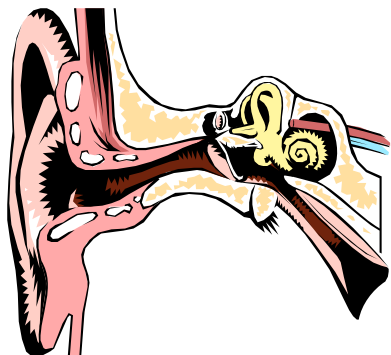
This effort reflects the AOA's commitment to improving communication with osteopathic medicine's professional family and is another example of the AOA moving from good to great.

AAO-HNS Update Removal of Part of the Endolymphatic Sac as a Treatment for Meniere's Disease

Endolymphatic sac surgeries have been controversial for a long time, but some patients do seem to gain benefit from them. In the past, the justification for these surgeries has been that the role of the endolymphatic sac is to reabsorb endolymph. It was thought that the sac wasn't doing its job properly in the Meniere's patient, which resulted in a build-up of endolymph (endolymphatic hydrops) and this caused the symptoms of the disease. Prior surgeries have been directed at helping the sac to work better, by either a "decompression" procedure (removing some of the bone around it) or by inserting a shunt, which is a tube through which the endolymph could escape. Now, one physician in Australia has found that surgically damaging (ablating) a portion of the endolymphatic sac gave better control of vertigo compared with decompression or shunt procedures. Although these observations may be surprising to some, they are in reasonable agreement with our present understanding of what the endolymphatic sac is doing. We now believe that the sac does not simply reabsorb endolymph. Instead, we now think it can reabsorb OR secrete endolymph as required. In the normal state, it appears to be balanced between these two possibilities (i.e. not doing anything) and probably contributes little to the maintenance of endolymph. It is only when an endolymph volume disturbance occurs that it switches on to reabsorb the excess, or to secrete more, as required. It is possible that the endolymphatic hydrops of some patients

may be because the endolymphatic sac is secreting endolymph when it should not be. Thus the sac may be causing the hydrops, by secreting when there is already a volume excess. If this is so, then damaging the endolymphatic sac may be an appropriate procedure. It is also possible that endolymphatic shunts and decompressions also act by partially damaging the endolymphatic sac, thereby reducing its capacity to secrete volume.

Reference: Gibson, WPR (1999) Removal of the extrasosseous portion of the endolymphatic sac. In: Meniere's Disease ED: Harri J.P. Kugler Publications, The Netherlands, pp 361-368.



Use of Tympanostomy Tubes as a Treatment for Meniere's Disease

Tympanostomy tubes (also called ventilation tubes or grommets) are little hollow tubes that are popped through the eardrum for the treatment of middle ear infections. They are commonly used in children and in adults can be placed as an office procedure. They remain in place for a while, then usually come out on their own, and the hole through the eardrum then heals up. In 1988, Montandon et al. reported that vertigo in Meniere's patients was controlled by placing a ventilation tube in the eardrum of the affected ear. Since then other reports have supported the observation Thomsen et al. (1998) compared the use of tympanostomy tubes with endolymphatic sac surgery in two groups of patients and found no significant differences between the two groups, indicating that tympanostomy tubes were as effective as an endolymphatic sac surgery. As the tympanostomy procedure is far less invasive and can be "reversed", it would seem preferable.

One reservation in the use of this technique has been the lack of scientific explanation for how it would work. However, there are a number of possible explanations, including possible changes in movements of the eardrum induced by swallowing and low-frequency sound, and

changes in the oxygen and carbon dioxide levels in the middle ear space which can influence the cochlear fluids.

References: 1) Montandon, P. Guillemin P. Haussler, R. (1988) Treatment of Meniere's disease by means of minor surgical procedures. In: Meniere's Disease. Editor: Nadol, J.B. Jr. Kugler & Ghedini Publications, pp 503-508; 2) Thomsen, J Bonding P., Becker B., Stage J., Tos M (1998) The non-specific effect of endolymphatic sac surgery in treatment of Meniere's disease. Acta Otolaryngol. 118, 769-773.



AOCOO-HNS Election and Voting Procedures

The nominees for 2007-2008 College Board positions have been accepted by the respective Colleges Boards. In this "Quarterly Report" the nominees will have their letters published for the membership to review. Nominations for College-at-Large positions must be submitted prior to voting. If any other nominee is submitted by a member, a petition for that nominee must be signed by a minimum of 10% of the voting membership and sent to the College Office. Deadline for petitions: February 1st, 2007.

Voting: Ballots for member voting will be included in the Spring "Quarterly Report" (mailed March 15th). Ballots may be returned by mail or fax to the Administrative Office (deadline April 1st). The ballots will be counted by the Executive Vice President, and then authenticated by the President or President-Elect of the individual College.

AOCOO-HNS Nominee for Secretary

Kirk W. Steehler, DO



The Colleges of the AOCOO-HNS represent us in matters involving the AOA, Capitol Hill, the general public, ourselves as a group and as individual members of the College. There is constant work managing growth, education and change. The

College's agenda is always full and it's meetings are always challenging. There is a significant amount of time spent by it's executive members and the members at large, handling the business and concerns of it's members.

I have served on the Board of Examiners and the Board of the College in some capacity for over twenty years. I accept the challenges of exciting times as well as the harness of routine work within the College. I have inspected residency programs, read countless resident papers, sat in on College sponsored retreats and program director meetings. I can honestly say I have gotten as much knowledge and satisfaction back from this experience as I have put in to the College. First and foremost, I have met professionals of the highest quality and integrity. This has given direction to my professional choices, practices and aspirations. There are many members of this College that have become my deep and meaningful friends. I have been able to see how other people meet and manage the day-to-day business and art of medicine. I get to see others work and I get to "steal" good ideas from great people. I advise anyone reading this to get involved with our College. Ask any one of us on the Board of Examiners or College Boards to show you how to get involved.

I now have the honor of running for a position on the Executive Board of our College. I would wholeheartedly accept this challenge and be available to the College needs. I am anxious to proceed with programs and policy that has been developed through membership input. I am ready to defend and support the Colleges as it winds it's way through all the unfunded mandates the government and the AOA put upon us.

I would be honored and excited if you would consider me for this executive position.

AOCO Board Member Nominees for 2007-2008

Members-at-Large to be Elected to a One-Year Term:

Robert Franchi, DO
David Gossage, DO
Jeffrey Holtzman, DO
Michael Krasnow, DO
William McLaughlin, DO
Brian Wind, DO

The Board has asked that each nominee submit a statement outlining their service to the College and/or desire to serve on the Board and reasons why they should be elected.

Robert J. Franchi, DO



I am flattered to have been nominated for an at-large position to the College. To date, I have served in several different capacities, which include, most recently, Chairman of the Professional Program for the Ophthalmology section in Miami, Florida and

Scottsdale, Arizona. I have submitted written questions for the Ophthalmology Certification Examinations and served on subcommittees including that of continuing medical education for the AOCO.

Having served the College and its membership, I have interacted with many board members in the spirit of cooperation and teamwork. I feel my prior experience and willingness for our College to grow in national stature will serve me well as an elected board officer.

Thank you again for your confidence in nominating me for this position.

David D. Gossage, DO



I would like to thank the nominating committee and the Colleges for their support in asking me to continue as a member-at-large. During the past year I had the opportunity to observe and participate in the College meetings and retreats to improve the

overall function of the Board. In November, I became the Councilor to the American Academy of Ophthalmology. Serving as the Councilor and as a member-at-large, I will be able to voice the concerns of our College members to the American Academy of Ophthalmology as well as our legislators in Washington, D.C.

Quality education has always been an

important part of why I became involved in the College. In the past, I have lectured and conducted several workshops for the Annual Clinical Assembly. I have served as a designated examiner and an exam writer for the ophthalmology boards exams. This year I began a new residency program in ophthalmology. I believe the future of Osteopathic Ophthalmology begins with a quality education, both didactic and surgical.

It would be a great honor to continue in the College as a member-at-large and I ask your support at election time.

Jeffrey N. Holtzman, DO



I am again honored by the Board's nomination for the position of member-at-large. I am currently serving this year as secretary of the AOCO and have been active in the College as a residency program director for many years. I

wish to continue to serve the AOCO as a Board Member.

Over the past 2 years, it has become very clear to me that the needs of our College are diverse and continually changing. I believe that the strength of our organization increases by the hard work of the membership and the dedication of its leadership. I would like to try to continue to contribute to the organization by fostering an attitude of openness and increasing involvement of as many members as possible. The new members in training and the new members in practice are the lifeblood of our College. As a residency program director I have attempted to instill the importance of involvement in our professional organizations to our young physicians. I would hope that my board position would allow me to help develop the future leaders of the AOCO.

Thank you for your support in the past and I hope I have represented you to the best of my ability. Please consider me as your representative to the Board for the coming year as Member-at-Large.

Michael A. Krasnow, DO



I am pleased to be nominated by the College to serve on the Board.

If elected, I will work to make the Board more accessible to the membership and to make the College Office more responsive to the membership. I would like

to have our College sponsor young members in leadership programs like the osteopathic health policy fellowship. I

would also like our College to find innovative ways to develop more residency programs in ophthalmology.

If elected, I will work hard to achieve these goals.

William M. McLaughlin Jr., DO



It has been my privilege to serve on the Board of the American Osteopathic College of Ophthalmology as a Member-at-Large for the past three years. Being a productive board member is truly a maturation process. I

have been frustrated at times feeling that my contributions up to this point have been limited. But with time I have come to understand that this is not unusual. As I have become more aware of the political process I am now able to see how I will be able to best serve the College. Armed with the knowledge I have gained I feel that, if elected, I will be a productive and responsible member who will look out for the membership interests to the best of my ability.

I am excited and look forward to continue to serve the College as a Member-at-Large of the Board.

Brian E. Wind, DO



I am honored to be nominated for the Member-at-Large position on the AOCO Board. As a member of this organization and past chair of the Practice Committee, I feel it is my responsibility to promote, support and advance the AOCO. As

medicine becomes more fragmented by external forces, I would strive to increase efficient communication between the AOCO physicians and utilize the untapped resources of many of our talented, though "quiet" members.

Having recently completed a three year term as Chief of Staff at Doctors Hospital in Stark County, serving as a Past President of the Eighth District Academy of Osteopathic Medicine, and participating in our local hospital's Physician Leadership Group, I have developed many skills to bring to the Board. Thank you for your consideration as I would be honored to serve on the AOCO Board as a Member-at-Large.

AOCO-HNS Board Member Nominees for 2007-2008

Members-at-Large to be Elected to a One-Year Term:

Paul Burk, DO
Michael Hauptert, DO
Donald Rothen, DO
Edward Scheiner, DO
David Short, DO
Christopher Surek, DO

The Board has asked that each nominee submit a statement outlining their service to the College and/or desire to serve on the Board and reasons why they should be elected.

Paul E. Burk, DO



I am honored to have served on the Board as a Member-at-Large in the past, and I thank you for your continued support in nominating me again this year. I have been a member of our College since 1987, Board Certified in 1989 and became a Fellow in 1991. As a

member of our College, I have attended every annual meeting since 1987.

With our College, I have served on several committees: 1999-2001 annual program chairman, 2001 workshop presenter, 2004-2006 ethics committee and chairman 2006, 1996-present residency ad hoc committee, chairman 2004-present, communications committee which has also involved contributing articles with the help of our residents to our Newsletter, and in 2004 received the Presidential Achievement Award. In 1989, I was instrumental in establishing our residency training program here in St. Louis and we have graduated a resident almost every year since then.

As resident trainers, our role is invaluable to the College with respect to increasing our membership and the continuation of a high level of excellence of our membership. I feel it is extremely important to continue our residency programs. Without residency programs, our College would dwindle in numbers and eventually cease to exist.

I have worked on several projects for the College in the past and am presently working on updating the surgical logs of Ophthalmology and Otolaryngology/Facial Plastic Surgery. This program is a computerized database which will allow the residents to store their surgical cases with more ease and transmit this information to the College electronically, avoiding all the paperwork. I am also presently working on

creating a generic residency manual—the idea is that a new residency program would not have to start from scratch or an existing program could use this to fill in any voids within their own program.

Another area I am working in is to help develop rotations/clinics in under-developed countries. A lot of discussion has occurred with regards to establishing our own clinic in one of these countries—which I think would be a great idea. However, in the mean time, I feel it might be beneficial to start rotations with an established clinic. I am working with the ENT departments of St. Louis University and Washington University to allow us to rotate through their established clinics in Honduras. I am hoping we can get this solidified for the Board meeting in February.

I will continue to work to meet the College's needs, and would be honored to serve our membership as a Board Member.

Michael S. Hauptert, DO



It is an honor to have been nominated as a candidate for the AOCO-HNS Board Member-at-Large position. I have always strived to represent our College and profession in a positive manner as well as to further the reputation of osteopathic otolaryngologists. I have been privileged to have been able to serve as a question writer and designated examiner in the past. Then I was fortunate to have been able to participate as a member of a Board of Examiners for seven years. This past year I have had the opportunity to serve as a Board Member-at-Large, thus familiarizing me with this position and the attendant responsibilities. I have been a recipient of the Governors' and Presidents' achievement awards.

Giving back to our profession is important to me. Without previous sacrifices by our predecessors and mentors, none of us would be able to practice the scope of medicine afforded us today. It has been my pleasure to help train numerous otolaryngology residents while they have rotated at Children's Hospital of Michigan. Hopefully I will be able to assist in the training of many more through my career.

I want to thank the nominating committee for considering me for this position and ask for your thoughtful consideration when you cast your vote for the position of Member-at-Large.

Donald M. Rothen, DO



I am honored to be nominated for a second term as a Board Member-at-Large. I have been a member of the College for over 30 years and it has really grown to be part of me. I have seen it grow from a small organization where we all knew each

other to one that is nationally recognized. I have been a program director of a residency program in otolaryngology/facial plastic surgery for over 25 years and am very proud of the successful accomplishments of the physicians who have graduated from the program. I am also involved in the education of the residents in 3 other programs in the area, and, as Associate Professor of Clinical Medicine at the Michigan State College of Osteopathic Medicine and Surgery, I am involved in the extern teaching program. I have been a question writer for the Board of Examiners and then was a member of the Board of Examiners for many years. I am presently a member of the Council of Medical Education as well as sit on the Practice Management and Editorial Committees. Along with Dr. Alvin Dubin, I had a significant role in the development of the Otolaryngic Allergy Program for our College. I also established the Certificate of Additional Training Program (CAQ) and the certification process in otolaryngic allergy.

As you can see, I have been actively involved and dedicated to this College for a long time; it is a significant part of my professional life. Education and the future of the College are very important to me and will continue to be. Through the years the College has been there to support me with education and friendship; I have tried to give a little of that back and would like to continue to do so as long as I can.

Edward D. Scheiner, DO



The following lists my involvement with the AOCOO: Member of the College since the start of my residency training in 1981. Attendance at every annual meeting since 1988. Direct involvement in residency training since starting in practice, and

Program Director of the residency training program at UMDNJ/SOM since 1996. Member of the Council of Medical Education since 2001, and a Member-at-Large of the College since 2005.

My desire to continue in my current role as a Member-at-Large of the College is fueled by my concern for the significant issues facing our specialists over the next several years. Involvement with residency

training at both the local and national level has given me insight into the many deleterious factors facing our organization and specialties. It is extremely important that the Officers of our College continue to advocate on behalf of our specialties the need for improved support by the AOA, and the Federal government. There is increasing need for continued and improved funding to allow our programs to maintain high standards in training programs, as well as to meet the needs for increased numbers of residents to meet the growing needs of the Osteopathic profession.

I look forward to continuing to work on behalf of our College to face the difficult issues facing us in the years ahead.

David G. Short, DO



With humility I accept the nomination to become a Member-at-Large. I am aware of the obligation and commitment of this position. If elected I will fulfill my position with enthusiasm, eagerness and an open mind.

All organizations have two fundamentally different tasks, to execute today's business as efficiently as possible and to device new directions for future success. In order to achieve that end I plan to demonstrate, by example, that active participation in our College is essential to the well being of our profession. In addition, I envision long-term strategies that would encourage the commitment of all by re-engaging the membership in all our meetings. As we all know, it is no longer sufficient in our working world just to be good, we must learn constantly and renew our professional and inter-personal competencies, in short, to accept the concept of life long learning.

In my ten years as a member of the Board of Examiners, I was instrumental in obtaining a Certificate of Added Qualifications in Otolaryngic Allergy from the AOA for our membership. As chairman, our Board was able to deliver an oral exam format that was comprehensive, psychometrically defensible and is currently being copied by the other specialty boards of the AOA. I have also served for 11 years on the Council of Medical Education helping set up protocols for resident education, resident programs as well as resident and program inspections. As an AOCO-HNS Member-at-Large, I will identify areas for change and have the courage to champion them to show leadership. No longer can you call yourself a leader simply because you attend a meeting. Leadership is a position of responsibility and I embrace it wholeheartedly.

Christopher L. Surek, DO



It is an honor to be nominated to be a Member-at-Large in our College. The Board and the College have been family to me since I was certified in 1986.

Through those nineteen years it has been a privilege to serve on the Board for twelve of those growing and maturing years, serving as a member-at-large for three years, assisting Dr. Alvin Dubin in obtaining the CAQ in otolaryngic allergy, presented lectures on three occasions at our annual meetings, established a residency program in Chicago, and a family practice program in Alabama, and have received the Presidential Achievement Certificate in 1996 and 2004.

If elected, I would continue to serve our College with the same commitment and dedication I have demonstrated in the past. Education for us and our future members is a major concern, as well as funding to keep our programs alive and growing. I have been privileged to work with so many of you over the years and look forward to doing so in the future.

ESTATE PLANNING . . .

New Pension Protection Act a Boon to Charitable Giving

*By David A. Berek**

(Reprinted from Illinois Bar Journal, November 2006, Volume 94)

THE NEW LAW ALLOWS WEALTHY TAXPAYERS OVER AGE 70½ TO GIVE UP TO \$100,000 FROM THEIR IRAs DIRECTLY TO PUBLIC CHARITIES

On August 17, 2006, President Bush signed the Pension Protection Act of 2006 (Pub. L. No. 109-280, 120 Stat. 780, hereinafter, the "Act"). This new law encompasses over 900 pages, many of which address employee benefit issues. There are, however, a number of helpful provisions for trust and estate practitioners to advise their clients. One of the new provisions addressing individual retirement accounts ("IRA") and charitable distributions can be especially beneficial to trust and estate practitioners in advising clients before year end, this year and next year.

CHARITABLE DISTRIBUTIONS NOW ALLOWED FROM AN IRA

Perhaps the most discussed provision in the new Act by trust and estate practitioners is the ability to make charitable distributions directly from a taxpayer's IRA. The first things practitioners need to determine is which clients this new provision will help. It is only applicable to taxpayers over age 70½, i.e., those already required to take minimum distributions. There are, however, a number of requirements and caveats to be aware of with this new provisions.

- Gifts to public charities only: The charitable distributions are limited to IRC section 170 (b)(1)(A) charities, otherwise known as public charities—and the Act specifically excludes private foundations.
- Limits on timing, amount of charitable distribution: The amount of the distribution from the IRA to the charity is limited to \$100,000 per year, and the provision is only available for tax years 2006 and 2007.
- No AGI charitable limitation: The distribution from the IRA is not included in income (see below), and the distribution to charity is not subject to the 50 percent adjusted gross income ("AGI") percentage limitation for itemized deduction. Thus, the distribution from the IRA does not affect the deductibility of other charitable contributions.

Moreover, if the taxpayer does not otherwise itemize, he or she receives a benefit by making the distribution from the IRA because the distribution amount will not be subject to income tax.

- Deemed distributed from deductible IRAs first: Since the distribution from the IRA is not included into income, it is advantageous for the taxpayer to apply the distribution first from deductible contributions (that otherwise would be subject to taxable income) rather than from nondeductible contributions, because only the earnings on nondeductible contributions are subject to income tax. So this is positive treatment for the taxpayer that is provided for as an ordering rule under the Act.
- IRAs not 401(k) Qualified Plans: The provision applies to IRAs and not qualified plans, although in many cases, the taxpayer should be allowed under the qualified plan document to rollover some or all of the qualified plan balance into an IRA, and then take advantage of the new provisions.

THE NEW LAW AND "REQUIRED MINIMUM DISTRIBUTION"

Another significant component of the charitable distribution from an IRA—one not expressly addressed in the new Act—is whether the distribution to charity is taken into account for required minimum

distribution ("RMDs") purposes. A related legislative document indicates that charitable distributions made from the IRA will offset the otherwise required RMD amount.

Recall that the provision only applies to distributions from IRAs owned by taxpayers over age 70½ who are required to receive RMDs. The Joint Committee on Taxation, however, produced a committee report explaining the provisions of the new Act. In that report, the committee indicates that "qualified charitable distributions are taken into account for purposes of the minimum distribution rules applicable to traditional IRA's".

Thus, if a taxpayer is required to receive a minimum distribution from his or her IRA in the amount of \$30,000 and he or she continues to make a \$20,000 distribution to charity, only \$10,000 is required to be distributed to the taxpayer as the RMD, and only the \$10,000 is potentially included into income (if it was a deductible contribution).

*David A. Berek is a family CFO with Credit Suisse Family Wealth Management and a member of the ISBA Trusts and Estates Section Council.

HEALTH AND WELLNESS

Matters of the Mind

Whether you are calculating multivariate statistics, or simply trying to stay alert during a long meeting—keeping your mind sharp matters. Luckily, the steps to exercising your brain are easier than you may think.

Exercise is just as healthy for your mind as it is for your body," explains Christine Blue, DO, an osteopathic psychiatrist specializing in general and geriatric psychiatry from Lewisburg, WV. "Regular physical exercise will not only help your cardiovascular health, but it will increase blood flow to the brain and help with your creativity and memory."

In addition, the calming benefits of exercising will reduce stress, which can cause memory problems. Physical activity can also prevent depression, which slows thinking. Exercise will clear the mind and allow for creative thinking and a problem-solving state of mind. For example, studies have shown that after walking for 15 minutes, individuals will increase their memory and ability to multi-task by more than 15%. Relaxation techniques, such as yoga and meditation, are also beneficial for the brain.

KEEP YOUR MIND SHARP WITH THESE 6 SIMPLE TIPS

- Stay curious and involved
- Attend lectures and plays
- Play games
- Work crosswords or other puzzles
- Continue your education
- Try memory exercises

There are several different memory techniques and exercises. One technique is called over-learning. This means that the individual would repeat and study something more than the topic might normally require. This technique might be employed when meeting new people. Oftentimes repeating the new name several times will help with remembering the person's name later.

Another memory technique that helps with remembering short lists of items is called the link or story method.

"Using this method, you would simply make up a story that links together the different items you want to remember," explains Dr. Blue.

In addition to exercise for the brain and body, Dr. Blue also recommends including these healthy vitamins and minerals in your diet:

ADD THESE VITAMINS AND MINERALS TO YOUR DIET

- Vitamin E—Vitamin E is found in all cells, including the cells of the brain. Damage to nerve tissue may result from a Vitamin E deficiency in the cells. You can eat foods like almonds, green leafy vegetables and whole grain flour to benefit from the different forms of this vitamin.
- Vitamin B—Every type of Vitamin B helps in preserving brain function and sharpness. Early brain development, declining memory and inability to focus have been linked with low levels of folic acid and Vitamins B-12 and B-6.
- Vitamin C—Eating plenty of broccoli, legumes, oranges, potatoes and strawberries will give you a large dose of this vitamin, which helps keep the brain healthy.
- Magnesium—Approximately 300 milligrams one to three times a day will help protect the brain from many substances that damage nerve cells.

DO Washington Update

Get Informed . . . Get Involved . . . Get Active . . . Contact Congress

Take Action

Congress departed DC for the Thanksgiving holidays, but plans to come back in early December to continue working on unfinished business. Keep up the pressure by continuing to send letters and make phone calls to your Senators and Representatives. Urge them to stop the 5% cut to physician payments in December. Your actions make a difference!

Status Update: Medicare Physician Payments

Lawmakers returned to Washington on November 13 facing many unfinished policy matters. During the months leading up to the elections, Members of Congress made promises that steps would be taken to overhaul the flawed Medicare payment system and halt the scheduled 5% payment cuts set to take place in January 2007. Many physicians are facing cuts of 10-15% due to the sustainable growth rate (SGR) formula, the expiring geographic adjustments, imaging cuts due to the Deficit Reduction Act of 2005, fee schedule adjustments based on the five-year review, and changes in the practice expense methodology.

With time running out and many changes in the makeup of Congress, the AOA, along with almost all specialty and subspecialty physician groups, has focused its efforts on reminding lawmakers of the promises that were made before the elections. AOA representatives are meeting with Republican leadership and staff, who are currently still in control of the legislative agenda, and with Democratic members who will serve in that capacity in the 110th Congress. The AOA is requesting more than another year of payments frozen at this year's level, believing that physicians' payments should be increased to meet the MedPAC recommendations.

In the House, many Members of the 109th Congress proposed changes to the current payment system, including: Chairman of the House Energy and Commerce Committee, Rep. Joe Barton (R-TX), Chairman of the House Ways and Means Committee, Rep. Bill Thomas (R-CA), Chairwoman of the House Ways and Means Subcommittee on Health, Rep.

Nancy Johnson (R-CT), and Ranking Member of the House Energy and Commerce Committee, Rep John Dingel (D-MI). All of these proposals are still circulating; while they contain differences in costs and provisions, each would stop the impending 5T cut in reimbursement payments. The Senate Finance Committee is also working towards a solution, and both current and future leadership are participating.

Cate Blankenburg
(cblankenburg@osteopathic.org)

Expansion of Physician Voluntary Reporting Program

The Centers for Medicare and Medicaid Services (CMS) is soliciting comments on its list of potential quality measures for its 2007 Physician Voluntary Reporting Program (PVRP). The goal is to have measures for every physician specialty to report under PVRP next year. The measure set builds on the original PVRP for 2006, and includes 86 measures covering 32 specialties. CMS plans to pick up subsets of these measures as the PVRP measures for next year. According to CMS, physicians will not be required to report all measures identified with their specialty. An updated PVRP measure set document will be posted this month for January 2007 implementation.

CMS indicates it will continue to update this list and include additional specialties in the PVRP program in 2007 as further measures are developed. Questions and/or comments can be sent to PVRP@cms.hhs.gov.

Carol Monaco
(cmonaco@osteopathic.org)

Senators Work to Prevent Limits on Graduate Medical Education in Non-Hospital Settings

On Monday, November 20, 57 members of the U.S. Senate sent a letter to Senate Majority Leader Bill Frist (R-TN) and Democratic Leader Harry Reid (D-NV) urging the Senate to take legislative action to prevent the Centers for Medicare and Medicaid Services (CMS) from limiting the training of physicians in non-hospital settings during the lame duck session. Sen. Susan Collins (R-ME) and Sen. Richard Durbin (D-IL) drafted the letter. The letter

re-affirms Congress' intent of encouraging and fostering rural and out-of-hospital training of physicians in non-hospital settings during the lame duck session. A similar lettered was also sent to Senate Leadership in 2004 and 2005.

Ray Quintero
(rquintero@osteopathic.org)

Part D Data Collection

Part D drug data will be used to "improve care," under a proposed rule by the Centers for Medicare and Medicaid Services (CMS). The proposed rule would allow the Department of Health and Human Services (HHS) and CMS to use Part D claims data for a wide variety of statutory and other purposes, including: 1) reporting to Congress and the public on the overall statistics associated with the operation of the Medicare prescription drug benefit; 2) conducting evaluations of the Medicare program; 3) making legislative proposals with respect to the programs the agency administers, including the Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP); and 4) conducting demonstration projects and making recommendations for improving the economy, efficiency or effectiveness of the Medicare program.

The agency says this Part D database will be "an important new tool to facilitate research, on a wide variety of topics that focus on improving the quality of and reducing the cost of health care services." The proposed rule would provide for the use of the claims information that is now being collected for Part D payment purposes for other research, analysis, reporting, and public health functions.

CMS does not believe current law restricts the agency from going forward with its plans for collecting Part D claims data. Under the proposal, the FDA, National Institutes of Health, the Agency for Healthcare Research and Quality, Office of Inspector General, Government Accountability Office, Congressional Budget Office and the Medicare Payment Advisory Commission also would have access to the data. Comments to CMS are due December 18th.

Carol Monaco
(cmonaco@osteopathic.org)

Pay-for-Performance Demonstration

The Centers for Medicare and Medicaid Services (CMS) has launched a pay-for-performance demonstration project as mandated by the Medicare Modernization Act (MMA). To participate in the Medicare Care Management Performance Demonstration, practices must participate in their state's Doctors' Office Quality-IT program (DOQ-IT) and be the primary provider of care for at least 50 Medicare patients.

The three-year demonstration, scheduled to begin next year, will take place in California, Arkansas, Massachusetts, and Utah. The Quality Improvement Organizations (QIO) in these states will send out applications to DOQ-IT participating practices by early January. In addition to requiring participation in DOQ-IT, additional criteria are required as this demonstration is focused on solo and small-medium sized primary care practices. Applications must be returned by April 15, 2007.

Under the demonstration, physician groups will be paid on a fee-for-service basis. Participating physicians will submit data annually on up to 26 quality measures related to the care of patients with diabetes, congestive heart failure, and coronary artery disease, as well as preventive health services such as immunizations and cancer screenings to high risk patients with a range of chronic diseases. A complete list of measures is available at www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp.

Carol Monaco
(cmonaco@osteopathic.org)

Hill Fact: Closest Race of 2006

The last edition of the D.O. Washington Update described the closest races of 2004 in order to demonstrate the power of a single vote. In light of some of the extremely close races that occurred in the election, it seems appropriate to revisit this topic once more. If you recall, the closest race of 2004 was between Rep. Charlie Melancon (D/LA-03) and Billy Tauzin, III, with a vote margin of 569. The closest race of 2006 yielded an even narrower victory. Remarkably, only 90 votes ousted Republican incumbent Rob Simmons (CT-02) in favor of his Democratic challenger Joe Courtney. Six other close races are still undecided. To see how your state fared, go to the D.O. Advocacy Action Center's Campaigns & Elections page.

Alissa Sims
(asims@osteopathic.org)

Ophthalmology Opportunities

ARIZONA

- Busy eye group with heavy medical and surgical caseload seeks BE/BC comprehensive ophthalmologist for full/part-time. Fellowships welcome. Competitive salary and benefits package leading to partnership. Contact Craig Cassidy, DO at 480-833-0014 or email: cassidyeyes@aol.com.

KENTUCKY

- Excellent opportunity to join a solo ophthalmologist, desiring to slow down. Opportunity for partnership after one year. Competitive salary and benefit package. Brand new office equipment. New office building. Associate with optometrist. New hospital with state-of-the-art outpatient surgery. Call Dr. Kay Hazelett 606-424-8721.

NEVADA

- Established otolaryngology/ophthalmology practice seeking BC/BE ophthalmologist to compliment group. The practice has three state-of-the-art offices in Henderson and Southwest Las Vegas Valley. All offices are located in community oriented high profile areas with one of the offices adjacent to the Seven Hills Surgery Center and the new Southwest office, located next to the new Southern Hills Hospital. Practice partnership and ASC opportunities available. Contact Judy Duncan at jduncan@nveyepa.com or 702-492-6928.

OHIO

- ENT/Head & Neck Surgeon in NE Ohio. BC/BE required. Active two physician practice with senior partner planning retirement after 36 years. Busy audiology, allergy and hearing components. State of the art facility and active community. If interested in this excellent opportunity, email drgwv@hotmail.com.
- Opportunity in Ohio—small town north of Dayton. General ophthalmology practice with partnership/ownership. Send C.V. and indicate intentions to: Gregory T. Schamaun, DO, 6050 St. Rt. 571 East, Greenville, OH 45331.
- Excellent anterior segment/glaucoma surgeon needed for group practice in Toledo. Salary plus incentive with buy-in after two years. Send C.V. to Ronald M. Kendrick, DO, 5555 Airport Highway, Suite 110, Toledo, OH 43615. Phone: 800-782-9214, FAX 419-865-3451.

PENNSYLVANIA

- Opening in a busy ophthalmology practice. Contact: Jane Kokinakis, DO, office # 800-845-8424.

WEST VIRGINIA

- Glaucoma specialist wanted. Join a team of two ophthalmologists and one optometrist bringing high quality care to Southern West Virginia. Best equipment available. Starting salary up to \$250,000.00. Shape your own practice but surgical opportunities are limited only by your skills. Contact mkrasnow@marshall.edu or call Bettie Chapman at 304-697-0393.

WASHINGTON

- OPH wanted in beautiful Washington State. Opportunity for someone interested in aggressively expanding a practice, or someone interested in working half-time and sharing the practice. A new DO medical school is being built in Yakima. There is opportunity for any level of participation. Hospital owned ASC with all new equipment. Call Dr. Leo Figgs 509-952-8545.

Otolaryngology Opportunities

ALASKA

- ENT wanted. Kenai Peninsula, S.W. of Anchorage. Excellent salary and benefits. Call or email: James Zirul, DO, 220 Spur View Drive, Kenai, AK 99611, call 907-283-5400, email jzirul@acsalaska.net.

ARIZONA

- 320 days of sunshine per year! Become part of a busy, expanding otolaryngology/head and neck/facial plastic surgery practice with full audiology services in the metropolitan Phoenix area. Seeking a BC/BE associate with early partnership opportunity to join our successful team. Competitive salary and benefits. Attractive lifestyle. Please contact Dr. David Mendelson (480) 894-5550 or fax CV to (480) 894-9469 or email to info@entsoa.com.

- Excellent Practice opportunity in Tucson. A busy two physician practice is seeking BC/BE ENT to join practice affiliated with two community based hospitals. Interested parties, including junior and senior residents, may call John Ruboyianes, MD or Joseph Small, DO at 520-795-1851.

FLORIDA

- Sunny South Florida, busy solo practitioner seeking associate. Fast-track partnership. Technically advanced offices. EMR/PM, Mini-CAT. Excellent compensation/Bonuses/Benefits. BE/BC. Contact ML 561-963-6313. Email: platinument@bellsouth.net.
- Central Florida Otolaryngology group is recruiting BC/BE otolaryngologist to join rapidly expanding practice. Two clinic sites, Leesburg and The Villages and our main OR site has accreditation from AAAASF. We have four BC ENT physicians, one of which is BC in Facial Plastic & Reconstructive Surgery. We have an Allergy department and complete audiology services with two doctors of audiology and a BC hearing aid specialist on staff plus electronic medical records. We offer good schools with a suburban lifestyle in beautiful Lake County. Excellent salary with partnership anticipated. Contact info: michelle.lakeent@earthlink.net or call 352-728-2404.
- Outstanding opportunity to join very busy otolaryngology/facial plastic surgery practice with partnership track income. Hollywood — Pembroke Pines, Florida. Contact: Dr. Craig Shapiro, 954-437-5333 or fax: 954-437-6252, shap62@aol.com.
- ENT job opportunity located in Ocala, Florida, one hour north of Orlando. Practice is looking for BC/BE general ENT/facial plastic surgeon to join group of 3 general ENT's. Contact Dr. Scott Nadenik, cellular 362-895-0285.

MASSACHUSETTS

- Work in the heart of beautiful New England. Extremely busy practice in North Central Massachusetts seeking associate. Currently one physician doing all aspects of general ENT. Shared call with three others. Community hospitals. This is an excellent opportunity with close proximity to mountains, beaches, and Boston. Contact Dr. Daniel Ervin at (978) 874-7368.

MICHIGAN

- Northwest Michigan practice opportunity. A busy 2 physician practice seeking BC/BE ENT to join practice affiliated with 2 community-based hospitals. For further information contact Andrew Mendians, DO at 231-843-6557 or mendians@voyager.net.

NEVADA

- Established ENT/OPH practice seeking BC/BE otolaryngologist to compliment group. The practice has three state-of-the-art offices in the Henderson and Southwest Las Vegas Valley. All offices are located in community oriented high profile areas with one of the offices adjacent to the Seven Hills Surgery Center and the new Southwest Office, located next to the new Southern Hills Hospital. Practice partnership and ASC opportunities available. For more information contact Judy Duncan at jduncan@nee-nv.com or 702-492-6928.

OHIO

- Seeking an otolaryngologist for position/ownership in an established practice located in Troy, OH. The practice has a well established patient base in Otolaryngology, Allergy and Facial Plastics. The practice has been in this location 20+ years. If interested, please contact Deborah or Georgia at 937-335-7278 or fax to 937-335-1783.
- ENT BC/BE needed in Newark, OH, 30 minutes east of Columbus. Need an additional solo practice physician, 167 hospital undergoing continual upgrading. Additional information can be obtained by calling Michael Ehler at 740-788-6010.

PENNSYLVANIA

- Busy otolaryngology practice in greater Philadelphia area looking for associate with partnership potential. Excellent compensation and benefit package. Contact: Dr. Ben Chack, 301 Oxford Valley Road, Suite 1201A, Yardley, PA 19067, phone (215) 321-6660.
- Excellent job opportunity in Chester County, minutes from Philadelphia. Very busy 3 physician ENT practice seeking an additional BC/BE otolaryngologist to join our practice. Unbelievable opportunity for early partnership. Contact Alex Keszeli, DO, at 484-437-8745.

TEXAS

- ENT practice opportunity in Corpus Christi. Large group, full practice with speech, audio, balance center, C.T. MRI and surgery center. Need two ENT and one neuro-otologist. Contact Troy Creamean, DO at 361-854-7000.

WASHINGTON

- Practice opportunity in the beautiful northwest. Seeking associate in general ENT and proficiency/interest in FPS, otology and allergy desirable. Contact: Palmer Wright, DO, 3999 Englewood Ave. #201, Yakima, WA 98902, 509-453-5300 or email palmer@yvn.com.

Otolaryngology Fellowships NEW YORK

- Pediatric otolaryngology fellowship starting 2004, 2005, 2006 at the Women & Children's Hospital of Buffalo. Exceptional opportunity for a 1 or 2-year fellowship covering all aspects of pediatric otolaryngology including complex otolaryngology, cochlear implantation, treatment of vascular birthmarks, laser surgery, airway management, maxillofacial trauma, facial plastics and sinus surgery. Clinical and basic science research is encouraged. Practice has five fellowship-trained pediatric otolaryngologists. Address inquiries to Philomena Behar, MD, email: pmbehar@aol.com.