

Quarterly Report

AOCO,
AOCO-HNS &
Foundation, Inc.

American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery - Spring 2007, Vol. 42 No. 2



ON THE BEACH

By Michael Williams

*At dawn, bare footed, viewing as
far as eyes can reach,
the water's edge advances and
recedes along the beach.*

*Before me I see a carpet of half-
buried shells of sea-creatures,
tide washed and rippled in sodden
sand along the beach.*

*I move, exploring, sodden sand
oozing between my toes,
beyond me the wavelets breaking
on the sand along the beach.*

*Behind me, my wandering trail is
blurred and indistinct,
as the water's edge advances and
recedes along the beach.*

*At mid-day, on the soft dry sand
behind the water's edge,
undressed worshippers lie in the
sun that beats down along the
beach.*

*At night, the moon's reflection at
the water's edge
resembles sea serpents playing in
the wavelets along the beach.*

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

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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



I look forward to seeing you in a few weeks in Sarasota. I expect a quality program at a great setting.

With this Newsletter it is your time to vote. The slate

this year represents the process of reducing our past Colleges to a smaller organization consistent with our recent Bylaw changes. In February the Executive Committee of the Board and Foundation, along with the Council of Medical Education met. Other than the normal businesses of our Colleges, we spent a great deal of the time on self-evaluation of our College leadership as well as of our organization itself. Included in the evaluation of the canvasses our Board did with members who we would like to be seeing more involved with our Colleges.

The Board sincerely evaluated your suggestion. We do try to balance these suggestions to meet the needs of our collective body. Some of these suggestions included content of the meetings. The Educational Needs Review Committee, currently chaired by Dr. Thomas Brandeisky, has been diligent in analyzing content for the meetings, and in my opinion, providing quality lectures to our organization in a diversity of topics without repetitiveness.

Suggestions of the time of our meeting, as well as location and cost, are constantly evaluated. Consideration includes choosing to have our meetings out of "high" season in order to keep the cost contained. The locations are selected on the basis of the best "bang for the Buck" rates. Locations are also considered on ease of travel to these locations. As you can see the next two conventions provide diversity being in Austin, Texas and then the following year we will be in Arizona again.

I have been a guest at the Council

of Medical Education chaired by Dr. Michael Rubin. I can assure you members, as an outsider looking in, that this committee and organization recognizes and is attentive to deficiencies in our programs. They diligently work to develop and correct these problems. As you can see elsewhere in this Newsletter, the Search Committee under the leadership of Dr. Carlo DiMarco is well prepared for finding a mentor for the Executive Vice President position. This is an important step for our growing Colleges and Foundation. This helps us in finding talent to fill these shoes.

Don't forget to VOTE—see you in Sarasota.

Kenneth H. Rogotzke, DO
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Board & Committee Reminder

The AOCOO-HNS Board of Governors and Foundation Board of Directors are meeting just prior to the ACA. Committee reports are due no later than April 2, 2007.

Your reports may be faxed (937-233-5673) or emailed (aocooahns@aol.com) to the Administrative Office - please comply with the April 2nd agenda deadline.

AOCOO-HNS FOUNDATION SILENT AUCTION

Shoib Myint, DO, Fundraising Committee Chairman

WE NEED YOUR TIME OR TALENT

PLEASE CONTACT DEBRA BAILEY at aocooahns@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



What a great opportunity lies ahead for Ophthalmology! The population over age 65 will be increasing from 31 million to over 70 million and people will be living longer. Chronic conditions, such as

glaucoma, will be nearly 50% higher; cataracts will be much higher as will macular degeneration. Recent studies have indicated a shortfall in physician supply by 100,000. At our Board Meeting in February, Hershey Bell, M.D. reported it may be as great as 200,000. Consequently, medical schools will be increasing enrollment and we will need many more programs for residency training to turn out ophthalmologists to meet the need.

If you have given any thought about starting a training program, I encourage you to contact the office in Dayton, Ohio for information on the requirements and process. We will do all we can to help you succeed.

Unfortunately, there is also a downside to the good news. In ten years, health care will be 20% of gross domestic product; and by 2014 federal and state governments will be paying the vast majority of health care costs for the country. In my opinion, this is tragic. Dr. Bell reported that the cost of funding training programs for the increase in medical school graduates would approach 10 billion dollars. All this added cost will undoubtedly result in further reductions in reimbursements.

Your Board had a program led by Dr. Bell helping us re-evaluate our responsibility to the Colleges. I am pleased with the dedication of the board members all putting forth considerable effort to continue making our organization meet the needs of the members. We welcome your comments and suggestions. I would encourage you to communicate with the Council of Regional Representatives (chaired by Dr. Steve Sherman) in your area and/or with the Council of Residents and Fellows (chaired by Dr. Scott Pfahler) to make known any concerns.

We are looking forward to a good upcoming annual clinical assembly in

Sarasota, Florida this May and hope to see all of you there.

Jacques L. Surer Jr., DO
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EXECUTIVE VP REPORT

Alvin D. Dubin, DO



The return of daylight savings time could not have happened at a more opportune time. The past many months have been spent in various activities that

continue to be reviewed, in order to bring to you improvements and awareness in your medical practice. The anticipation of Spring, more daylight, together with a sense of accomplishment in the many activities of the College leads one to say that the "glass is half full", and our May meeting will justify that feeling.

The Colleges' are working with the new structure and feel confident that they will function in a more effective manner when dealing with Board responsibilities. The President-Elect of each College is reviewing the Committees' as to specific charges of each, and composition, as well. Preparation in these matters is now taking months, as it should be, and with this greater insight and direction, we expect the Committees' to be a main source of development to the Colleges' future endeavors.

The Boards have spent quality time and effort participating in a Retreat designed to revisit our vision, mission, sense of being, and Leadership qualities of the Board Members, and it is hoped eventually all College members, as well. We look forward to sharing the fruits of this retreat with you at the ACA. It is hoped that with your participation in these efforts, we may all benefit from the job ahead—practicing medicine.

There is no magic or secret hidden site revealing new innovative answers, but by taking a long, hard and realistic look at the world we face, we come to terms not only with surviving, but doing so with success. This leads to my next statement. It is

incumbent upon all of us to learn about Federal Health Policy Issues. We must also learn how we can make a difference by lobbying in our legislatures. We must learn from local, state, and national societies, including the AOA, AMA, AAO and the AAO-HNS. We must continue to support the various PAC activities, learn who our representatives are (local and national) and introduce ourselves to them.

Like it or not—government action affects every aspect of practicing medicine. This ranges from treating medical problems to physician reimbursement. That is why we need to be involved in the legislative process. Those in Congress and Statehouses need to be informed how their decisions affect our practices and our patients.

Our primary responsibilities that deal with resident training issues, have been updated by the Council of Medical Education. Their many recommendations have been sent to the AOA, and to Program Directors, Residents, DME where feasible, in order to continually improve all aspects of GME.

The Board of Governor's Executive Committee has approved several motions that will facilitate closer relations with Resident Members, Members, and it is hoped College and Certifying Board as well. When these are approved by the Board of Governors at the ACA, they will be published and sent to you so that all may benefit.

I look forward to seeing you all in May at the ACA in Sarasota, Florida.

Did you give a contribution of \$500 or more this year to the Foundation? If yes, you are invited to attend a Special Reception on Thursday evening, May 3rd at the Ritz-Carlton in Sarasota, Florida.

**PLEDGE \$500 TO
THE
FOUNDATION
TODAY!**



AOCOO-HNS Member News

CHARLES F. SCHRIMPF, DO

On December 9, 2006 Dr. Charles Schrimpf was honored by Grandview and Southview Hospitals with the Distinguished Service Award.

Dr. Schrimpf remembers back in the early days when "we had to contribute to a bed tax" at Grandview Hospital. But his loyalty to Grandview combined with his admiration of osteopathic medicine, helped him gladly pay the tax in order to see Grandview Hospital thrive.

A native of Cincinnati and son of a physician, Dr. Schrimpf graduated from the University of Dayton. Dr. Schrimpf's father was an MD but when it came time to attend medical school, he chose the Chicago College of Osteopathic Medicine. He came to Grandview Hospital for his internship and on to the Kansas City College of Osteopathic Medicine for a residency in ophthalmology. "I scrubbed for surgery as a teen with my father. He was thrilled I became a doctor."

Dr. Schrimpf, who admits he's always been more interested in the educational aspect of the hospital over the administrative side, has served as chairman of the department of ophthalmology at Grandview Hospital since 1968. "As long as I can do it, I'll go into the clinic a couple of days a week." Through his membership in various national ophthalmologic organizations, Dr. Schrimpf has many great friends across the country. "We all speak the same language."

Dr. Schrimpf would recommend the field of medicine to young people thinking about a career. "It's one of the few areas where you're face to face with someone and truly helping them." He has seen the technology in this field expand at a phenomenal pace and he credits engineers who have created the tools that make surgery so much safer. "We have so much more sophisticated equipment. It makes the procedure quicker, safer and recovery much faster."

Dr. Schrimpf has trained 32 ophthalmology residents over the years "and by and large they are all very good." When the eye clinic at Grandview was named after him, Dr. Schrimpf was honored and surprised. He's proud of Grandview and its physicians "Back in the day, we had to show ourselves as first-class physicians. Every day was a

hurdle. Our diagnoses were good. This place has good doctors."

This Distinguished Service Award was established in 1985 by the medical staff at Grandview and Southview Hospitals to honor members who have made outstanding contributions to the growth and academic excellence of both hospitals, the staff and the osteopathic profession.

Criteria for selecting recipients include a pioneering spirit, the introduction of innovations and improvements, teaching and training, as well as service to the staff and the osteopathic profession. Recipients are physicians and individuals recognized for their high moral character, integrity and dedication to osteopathic medicine.

The AOCOO-HNS congratulates Dr. Schrimpf and is proud of his local and national accomplishments.

LEONID SKORIN JR., DO

Dr. Leonid Skorin Jr. has been appointed Co-Editor-in-Chief of the Canadian Journal, *Clinical and Surgical Journal of Ophthalmology*. He shares his position with his Canadian counterpart, Francis Roy, MD, of Trois-Rivieres, Quebec. He is the first United States and first DO ophthalmologist to hold this position. He has also been appointed to the Board of Directors of the Canadian Society of Cataract and Refractive Surgery (CSCRS). The CSCRS exists to enhance the quality of cataract and refractive surgery in Canada through research, education, academic exchange and communication with government, other professionals, other organizations and the general public.

Closer to home, Dr. Skorin is the recipient of the Albert Lea Medical Center's (ALMC) "Distinguished Clinician Award for 2006". ALMC's Distinguished Clinician Award is given annually to a clinician who personifies excellence in healthcare. Nominated by colleagues the clinician must meet several criteria including being a person who is sought out by other physicians as a problem solver, dedicated to ALMC values; participates in committee activities and contributes to the broader community; and, goes the extra mile to support colleagues and patients.

The AOCOO-HNS congratulates Dr. Skorin and is proud of his local and national accomplishments.

Bylaw Committee Report

Carlo J. DiMarco, DO, Chair

The Bylaw changes below will be submitted to the general membership for a vote at the annual membership meeting on Friday, May 4th, 2007 at the Ritz-Carlton in Sarasota, Florida.

ARTICLE IV
MEMBERSHIP IN THE AOCOO-HNS
Section 1. Categories of Membership are:

- A. Resident member
- B. New member
- C. Active member
- D. Life member
- E. Retired member
- F. Honorary member
- G. ASSOCIATE MEMBER
- H. AFFILIATE MEMBER

SECTION 8. {NEW}
ASSOCIATE MEMBER (NON-VOTING)
MUST:

- A. BE A GRADUATE OF AN AOA ACCREDITED OSTEOPATHIC MEDICAL SCHOOL.
- B. HAVE SUCCESSFULLY COMPLETED ONE YEAR POST GRADUATE TRAINING PROGRAM APPROVED BY THE AOA AND/OR ACGME.
- C. BE A MEMBER OF THE AMERICAN OSTEOPATHIC ASSOCIATION.
- D. BE LICENSED TO PRACTICE OSTEOPATHIC MEDICINE OR SURGERY.

SECTION 9 {NEW}
AFFILIATE MEMBER (NON-VOTING)
MUST:

- A. BE ACTIVELY INVOLVED IN AN ANCILLARY MANNER IN A PRACTICE OF MEDICINE (PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED CERTIFIED TECHNICIAN), NOT TO INCLUDE CHIROPRACTORS, DENTISTS, OPTOMETRISTS OR PODIATRISTS.

Section 10. {old Section 8}
Dues, Fees and Assessments: There will be annual active member dues, new member dues, ASSOCIATE MEMBER DUES, AFFILIATE MEMBER DUES. There may also be fees and assessments. Only members who have satisfied their financial obligations to the

AOCOO-HNS shall be considered a member in good standing.

Section 11. {old Section 9} unchanged

Section 12. {old Section 10} unchanged

Section 13. {old Section 11} unchanged

AOCO Communications Committee Report

James E. Silone Jr., DO

MANAGING PATIENT FLOW PROBLEMS

If your practice is anything like ours, patient flow can sometimes be a problem. We don't usually have patients falling asleep in our lobby from long waits, but I can be honest and say that not every patient is brought back within 15 minutes of their appointment time. So, I did what any anal retentive physician does, I set out on a project to analyze the etiology of the problem (or I guess I should say problems) and to see if I could make things better. I want to share with you some of the things I discovered.

What I have found through attending lectures at annual meetings, and speaking to other practices is that patient flow is a constant and complex challenge, but it can be optimized if you take the necessary steps. The one thing we did that seems obvious now is to calculate exactly how long an exam takes. You can do this by doing a time study. The reason a time study is so important is that if you have appointments scheduled 10 per hour and yet it takes you 10 minutes to do each exam it is pretty evident to discover that the age old question of "Why am I always so far behind at mid-morning and mid-afternoon?" is that you are only seeing 6 patients per hour and you have 10 scheduled. Unfortunately, you can't schedule more than 60 minutes of your time per hour (the same goes for your technicians and nurses).

A time study involves evaluating each type of exam and the individual components of each exam. So in our practice we look at long, medium and short exams. We then measured the time of each exam component (history, vision, refraction, etc.). We then took averages of each type of exam and each component and used the data to make a new appointment schedule.

Prior to making up a new schedule, the other thing we found necessary was to calculate how many technicians and exam rooms are needed for the number of patients you would like to see. Most of this will be based on how many of the individual exam components you delegate to your technician staff, the number of exam rooms you have, and the number of physicians that are seeing patients.

So based on the above, if you find that a long exam takes a total time of 30 minutes, it will depend on what percentage of the exam the physician and technician each perform. If you do the entire work-up and exam without any technical support, each 8 hour work day you could only see 16 patients. However, if you performed the exam only and left the majority of the history and work up to your technicians and nurses, the number of patients you could see may be increased up to 8 per hour for a total of 64 patients in a work day. With regards to number of technicians and exam rooms necessary, it again depends on the work load you place on your staff. If you are by yourself and do everything, you could get away with one exam room. However to see 60 plus patients a day, you may need 4-6 exam rooms and 3-4 technicians depending on efficiency. All of these numbers are per doctor. So if you have a 3 person group and each physician would like to see 60 plus patients per day, you may need 15 exam rooms and 10-12 technicians.

Since we have a fixed number of physicians in our practice (3) and a fixed number of exam rooms (11), we tried to optimize our flow by creating a new schedule based on our time study. We try to keep only two physicians in the office when we can, as this allows us to see the number of patients we would each like to see. We also adjusted the schedule to allow for the type of appointments (long, medium or short) that each individual physician was seeing the most. This has allowed us to have better patient flow and less patient complaints for wait times in our office. It takes at least 4 to 6 months to make all of this happen and possibly up to a year to continue to make changes to find the optimal schedule.

So what other common problems can still disrupt a new schedule? The following will show you some of the solutions we use.

PROBLEMS (SOLUTIONS)

- Patients take too long to register— (Mail forms before appointment)

- Techs can't work up when doing testing—(Schedule one tech to do testing, i.e., VF's, etc.)
- Work-ins, Emergencies—(Save appointment slots for emergencies)
- Late patients—(Work in if possible, if not reschedule)
- No shows—(Reminder 1-2 days in advance)

I hope some of these ideas and tips help. They have helped our practice, and although things aren't perfect, they continue to improve. I think your patients will appreciate the effort.

AOCO-HNS Communications Committee Report

Paul E. Burk, DO

RETROPHARYNGEAL ABSCESS

Background

A retropharyngeal abscess is an infection in one of the deep spaces of the neck. An abscess in this location is an immediate life-threatening emergency, with potential for airway compromise and other catastrophic complications. Physicians must be familiar with the diagnosis and treatment of a retropharyngeal abscess.

In order to understand deep space infections, a working knowledge of the anatomy of the various fascial planes in the neck is necessary. Several layers of superficial and deep fascia are found in the neck. While some are tightly adherent to their adjacent structures, potential spaces (i.e., soft tissue planed bordered by fascia) separate other layers of fascia. Normally, no actual space exists; however, an infection can create a real space with rapid spread of inflammation and pus in the space between the fascial layers.

The retropharyngeal space is located immediately posterior to the nasopharynx, oropharynx, hypopharynx, larynx, and trachea. The visceral (i.e., buccopharyngeal) fascia, which surrounds the pharynx, trachea, esophagus, and thyroid, forms the anterior border of the retropharyngeal space. Bounded posteriorly by the alar fascia, the retropharyngeal space is bounded laterally by the carotid sheaths and parapharyngeal spaces. It extends superiorly to the base of the skull and

inferiorly to the mediastinum at the level of the tracheal bifurcation.

Pathophysiology

The retropharyngeal space can become infected in 2 ways. Either infection spreads from a contiguous area or the space is inoculated directly secondary to penetrating trauma. Typically, an upper respiratory infection (URI) causes spread to retropharyngeal lymph nodes, which form chains in the retropharyngeal space on either side of the superior constrictor muscle. Sources of infection can include pharyngitis, tonsillitis, adenitis, otitis, sinusitis, and other infections (i.e., nasal, salivary, dental). Infectious sources (eg, osteomyelitis of the spine) also can spread anteriorly from the prevertebral space.

Penetrating trauma is involved prominently in retropharyngeal space infection. Accidental lacerations are not uncommon in children who run and fall down after they have placed an object (eg, toy, stick, frozen popsicle, lollipop, toothbrush) in their mouths. Foreign bodies (eg, fishbones) also have been implicated in penetrating trauma to the retropharyngeal space. Iatrogenic causes of inoculation to this space include instrumentation with laryngoscopy, endotracheal intubation, surgery, endoscopy, feeding tube placement, and dental injections and procedures.

Complications of retropharyngeal abscesses are secondary to mass effect, rupture of the abscess, or spread of infection. The most urgent complication involves the abscess expanding against the pharynx or trachea, causing airway compression. Rupture of the abscess can cause aspiration of pus, resulting in asphyxiation or pneumonia. The infection can spread, resulting in inflammation and destruction of adjacent tissues. Spread of the infection to the mediastinum can result in mediastinitis, purulent pericarditis and tamponade, pyopneumothorax, pleuritis, empyema, or bronchial erosion. Spread of the infection laterally can involve the carotid sheath and cause jugular vein thrombosis or carotid artery rupture. Posterior spread of infection can result in osteomyelitis and erosion of the spinal column, causing vertebral subluxation and spinal cord injury. The infection itself can evolve into necrotizing fasciitis, sepsis, and death.

Treatment

Determining airway stability remains a top priority. Allow patients to remain in a position of comfort, which is usually supine with their necks extended. Neck flexion or forcing a child to sit up can occlude the airway.

Sometimes positioning is all that is necessary to maintain airway patency. Administer supplemental oxygen as needed. Provide a definitive airway only under direct visualization. If this is not possible due to trismus or distorted anatomy, abort the attempt. Excessive manipulation or blind oral or nasotracheal intubation can cause abscess rupture with catastrophic consequences. Consider either fiberoptic intubation or a surgical airway.

After obtaining a CBC and blood cultures, initiate empiric antibiotic therapy without delay.

Broad-spectrum coverage is indicated. Clindamycin is first-line treatment. Given the increasing frequency of resistant bacteria, treatment may be initiated alone or in combination with cefoxitin or a beta-lactamase-resistant penicillin, such as ticarcillin/clavulanate, piperacillin/tazobactam, or ampicillin/sulbactam.

Patients with cellulitis can be treated with parenteral antibiotics alone. Closely observe these patients for development of an abscess. Some authors advocate the use of antibiotics alone for small abscesses. These patients need to be monitored closely for improvement. A CT scan may be helpful in distinguishing cellulitis from an early abscess.

Surgical Care

Surgical airway control may be necessary in patients whose airways are difficult to visualize or are obstructed completely. Depending on the age of the patient and the experience of the physician, perform needle cricothyroidostomy or cricothyroidotomy only if the child cannot be transported to the operating room safely or quickly enough to secure the airway there. Alternatively, a qualified surgeon can perform a tracheotomy.

Needle aspiration of an abscess can be performed both to assist in diagnosis and to treat an abscess. This only should be performed by a qualified surgeon in the operating suite. Definitive airway management should be immediately available.

- A small retropharyngeal abscess

can be aspirated with an 18-gauge needle by the intraoral route.

- Larger abscesses require incision and drainage using either an intraoral or transcervical approach or both, depending on the location of the carotid sheath in relationship to the abscess.
- Completely evacuate pus from the abscess. Send a specimen to the lab for Gram stain, culture, and sensitivity.
- Abscesses in the parapharyngeal space isolated lateral to the carotid sheath can be aspirated by an external approach.
- CT scan or ultrasound may be used to help guide the aspiration.

The patient should remain intubated. Place the patient in an ICU setting for several days postoperatively to stabilize the airway.

Abscesses with extensive spread or those involving multiple deep spaces must be incised and drained via an external approach and transoral approach as necessary.

- Make an incision along the anterior border of the sternocleidomastoid. Retract the carotid sheath and open and evacuate the deep spaces. Send a specimen of the abscess wall, along with some pus, to pathology for culture and sensitivity.
- If mediastinal involvement is present, an open incision and drainage of the neck can be extended down to the level of T4. Alternatively, the surgeon can perform a thoracotomy.

Empyema and pyopneumothorax may require multiple chest tubes. Carotid artery rupture most likely requires ligation.

AOA News

News Advisory: Sleep Awareness Week 2007

PHYSICIANS AVAILABLE TO DISCUSS SLEEP DISORDERS IN CHILDREN

It is no secret that many adults do not get enough sleep, but often overlooked are children who can also suffer from sleep disorders that can snowball into a host of other problems. A 2006 poll by the National Sleep Foundation found that children get an average of 1.5 hours less than the recommended 10 to 11 hours of sleep per night on school nights, and nearly half of all adolescents

sleep less than eight hours on school nights.

Insufficient sleep can lead to problems such as headaches, inability to perform well in school and depression. In conjunction with National Sleep Awareness Week®, March 5-11, osteopathic physicians are available to discuss reasons children have trouble sleeping, problems associated with lack of sleep, and offer advice on how to help children overcome sleep problems. Physician sources include:

Brian H. Foresman, DO

Director, Sleep Medicine and Circadian Biology Program, Indiana University School of Medicine in Indianapolis, Ind. Former Medical Director, Midwest Regional Sleep Disorders Center in Indianapolis, Ind.
Board certified in sleep medicine

Stephen H. Sheldon, DO

Director, Sleep Medicine Center, Children's Memorial Hospital in Chicago Professor of Pediatrics, Northwestern University's Feinberg School of Medicine in Chicago
Distinguished Service Award, American Academy of Sleep Medicine, 2006
Board certified in sleep medicine and pediatrics

AOA-DO Washington Update

MedPAC Report Calls for Greater Investment in CMS

While MedPAC commissioners could not agree on how or whether to use expenditure targets for the Medicare payment system, they did agree that “a major investment should be made in Medicare’s capability to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.”

The Deficit Reduction Act required MedPAC to examine alternatives for controlling physician expenditures under Medicare. MedPAC said that an expenditure target cannot substitute for

improvements to Medicare payment systems and that, in absence of other changes, an expenditure target could stimulate inappropriate behavior, including increases in volume and intensity that the target system is supposed to control. The commission sees an expenditure target as a tool for altering the behavior of policy makers rather than as a tool for improving how physicians and other providers deliver services.

In its report, *Assessing Alternatives to the Sustainable Growth Rate System*, the commission stated that Congress must either repeal the SGR and not replace it with a new system altogether; or replace it with a new target system. If Congress chooses to use expenditure targets, they should apply to all Medicare providers, not just physicians.

Regardless of which path Congress chooses, MedPAC said Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers. According to MedPAC, Congress needs to provide the Centers for Medicare and Medicaid Services (CMS) with the necessary time, financial resources, and administrative flexibility to make these improvements. “CMS will need to invest in information systems; develop, update, and improve quality and resource use measures; and contract for specialized services. In the long run, failure to invest in CMS will result in higher program costs and lower quality of care.” For the full report, go to www.medpac.gov.

Congress Holds Hearings on Physician Payment

In early March, both Senate and House committees held hearings that focused on the current broken physician payment system and the recommendations included in the MedPAC report.

On March 1, the Senate Finance Committee held a hearing entitled “Medicare Payment for Physician Services: Examining New Approaches.” Committee Chairman Max Baucus (D-MT) and Ranking Member Charles Grassley (R-IA) agreed that the current system is flawed and is not functioning as intended. They also agreed that a long-term solution must ensure that physicians can afford the practice of medicine while also ensuring beneficiary access to care. A new system must be predictable while demanding quality and

efficiency to create long-term sustainability. Although in their respective opening statements both members expressed disappointment that the MedPAC report did not provide a clear alternative to the current system, they agreed that they must “jointly roll-up their sleeves” to find a suitable alternative.

On March 6, both the House Ways and Means Subcommittee on Health and the Energy and Commerce Subcommittee on Health held hearings. Ways and Means Chairman Pete Stark (D-CA) addressed the temporary fixes that have been implemented in past years as inadequate and merely deepening the hole we are currently in as a result of the flawed SGR formula. He is hoping for a long term fix in order to correct the inequities in payment that exist. Ranking Member Dave Camp (R-MI) agreed that a long-term solution must be found and further asserted the necessity of working with both MedPAC and physicians to do so.

During the Energy and Commerce Health Subcommittee hearing, entitled “Exploring Options for Improving the Medicare Physician Payment System,” Chairman Frank Pallone (D-NJ) said that he remained committed to finding a permanent solution to avoid “kicking the can down the road” for another year. However, not every member of the subcommittee was that optimistic. The frustration with MedPAC’s inability to come to a clear consensus on what steps Congress should take in improving the Medicare physician payment system were echoed by almost every lawmaker in the room.

Glenn Hackbarth, Chairman of the Medicare Payment Advisory Committee, testifying at both House hearings, explained the intricate connection between efficiency and improved quality of care and outlined the two pathways presented in the report. He also made it clear that the MedPAC membership is split on the issue of spending targets and whether or not they are useful and/or should be a part of the new payment system. He does not feel that targets alone are an adequate means to increasing efficiency or improving quality, nor does he believe that physician spending and its associated costs are the only problem.

It is expected that discussions on how to fix the Medicare physician payment system will continue in all three committees.

CMS States that Medicare Physician Payment is at a Crossroads

While addressing the Practicing Physicians Advisory Council (PPAC), Herb Kuhn, Acting Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS), told members that Medicare physician payment is at a crossroads. The agency is anticipating a 9.9 percent cut in physician payments for 2008 and continued reductions for the next decade. The goal, according to Kuhn, is to transform Medicare into an active purchaser of services.

As part of that effort to transform Medicare, the agency is developing the Physician Quality Reporting Initiative (PQRI). The final list of 74 measures is posted on the PQRI web site at www.cms.hhs.gov/pqri. Detailed measure specifications will be posted on the web site soon - possibly sometime in March. CPT II codes or temporary G codes will be used to report quality data. Quality codes must be reported on the same claims as the payment codes. The program is voluntary and participants are eligible for a 1.5 percent bonus. Questions about the PQRI?

In other PPAC news, approximately 13 percent of Medicare claims are being submitted with the new National Provider Identifier (NPI). The agency does not have absolute numbers, but approximately 80 percent of providers now have an NPI. Physicians and other providers have until May 23 to comply with the NPI. PPAC members expressed concerns that if only 13 percent are using NPI now, problems may arise come May 23 if everyone switches to NPI at once. PPAC members also asked when the agency would release its data dissemination notice regarding the use of the NPI. CMS hopes to have the notice out by May 23. for more information on the NPI.

Senate Hearing on FDA Regulation of Tobacco

On February 27, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing on the Food and Drug Administration (FDA) regulation of tobacco and tobacco products. Committee Chairman Ted Kennedy (D-MA) has sponsored legislation that would give the FDA authority to regulate the marketing tactics of tobacco companies as they relate to sales to minors, and regulate claims that could be misleading to the public about the use of tobacco products. This would

include the evaluation and regulation of cigarettes and the addictive and harmful chemicals contained in them.

Ranking Member Michael Enzi (R-WY) remarked that requiring the FDA to "approve" a product that is ultimately harmful undermines the Agency, saying it "guts the authority the Agency has to remove health threats from the marketplace." Sen. Tom Coburn (R-OK) stated that the mission of the FDA is to "evaluate safety and efficacy" and that there is "nothing safe or efficacious about cigarettes." Sen. Richard Burr (R-NC) offered the panelists a scenario under which the Federal Trade Commission (FTC) and the Department of Justice would regulate a Congressional mandate on the packaging and marketing of cigarettes; each responding that the FDA is the only authority they would accept. The Senate HELP committee is expected to continue this debate later this year.

Hill Fact: Youngest House Members

When most Americans picture their Members of Congress they conjure up images of silver-haired politicians. However, there are also several young Congressmen walking the halls of the U.S. Capitol. Do you know who they are? Read below to learn who the top ten youngest Representatives are!

Member	Birth Date
Patrick McHenry (R/NC)	10/22/1975
Adam Putnam (R/FL)	07/31/1974
Patrick Murphy (D/PA)	10/19/1973
Devin Nunes (R/CA)	10/01/1973
Christopher Murphy (D/CT)	08/03/1973
Dan Boren (D/OK)	08/02/1973
Tim Ryan (D/OH)	07/16/1973
Heath Shuler (D/NC)	12/31/1971
Bobby Jindal (R/LA)	06/10/1971
Adrian Smith (R/NE)	12/19/1970

Report of the AAO Counsel Meeting and Surgery by Surgeons Progress Report **By David D. Gossage, DO**

Since the Oklahoma laser bill pass in 1998, the Surgical Scope Fund has helped 25 states reject optometric surgery language. Recent accomplishments:

- Have made significant gains in Oklahoma every year since the state fell to optometry in 1998. For example, 72% of Oklahoma citizens in a recent statewide survey voiced their opposition to optometrists performing surgery on their eyes—an essential step toward rescission of the O.D. surgery law.
- Defeated a dangerous O.D. injections bill in Alaska in 2006.
- Defeated a New Mexico bill in 2005 authorizing O.D.s to perform laser surgery and injection procedures. Just last year, we derailed optometry's effort to bypass the normal legislative process by countering their attempt to introduce a special session bill.
- Stopped a Texas bill in 2004 authorizing O.D.s to perform surgery.
- Helped ophthalmologists win nine legislative surgical scope-of-practice battles in 2004.

2007 RED ALERT STATES:

ALASKA

In January, the optometry lobby introduced legislation (H.B.113) that would allow optometrists to perform a variety of injection procedures, including fluorescein angiography, botox injections, intravenous infusions and administration of local anesthetics.

CALIFORNIA

In 2006, optometrists successfully elected one of their leaders to the state legislature—an optometrist who is a former president of the state optometric association and who has served as the chair of the state optometry board. As of Nov. 2006, the state optometric association had a political war chest of more than \$750,000—almost as large as their national PAC. California could be the next surgical battleground.

AOA Fact of the Day

DID YOU KNOW that AOA members can receive discounts on the Chicago Museum of Science and Industry's Body Worlds 2 exhibit? The AOA is partnering with the Museum of Science and Industry to spread the word about the exhibit, Gunther von Hagens' "Body Worlds 2: The Anatomical Exhibition of Real Human Bodies." This awe-inspiring exhibit offers an amazing opportunity to investigate the mysteries of human anatomy and physiology and showcases more than 200 real human specimens and more than 20 new full-body "plastinates." Please visit www.msichicago.org/bw2/pdf/discount.pdf.

NEW MEXICO

Last month, the optometrists introduced a dangerous expansion bill (S.B.367) that exposes all of our patients to serious risk by allowing them to perform numerous invasive surgical procedures, administer pharmaceuticals and perform injections. The bill would authorize the N.M. optometry board to certify optometric use of lasers, including SLTs, ALTs, YAG capsulotomies, YAG PIs and ARGON PIs.

TEXAS

In 2005, optometrists introduced legislation to perform invasive surgical procedures. The legislative rules prevented the optometrists from re-introducing their anti-patient bill in 2006, but we are expecting their return in 2007.

2007 WATCH LIST:

The Academy is monitoring O.D. oral prescribing bills in Indiana, Georgia, New York and Massachusetts. While the Surgical Scope Fund is not used to fight O.D. prescribing bills, any one of them can be amended during the legislative process to include surgery.

NEXT GENERATION MEASURES: SHIFT FROM PROCESS OF CARE MEASURES TO INTERMEDIATE OUTCOMES AND INDICATORS OF PHYSICIAN COMPETENCY AND SKILLS

In the past year of aggressive development of eye care performance measures, with the help of several of the subspecialty societies and their representatives, we were successful in developing 8 measures in 4 areas: age-related macular degeneration, diabetic retinopathy, cataract and primary open-angle glaucoma. These were approved by the AMA's Physician Consortium for Performance Improvement (PCPI) in October 2006. These were then successfully approved by the AQA Alliance and incorporated by CMS for the PVRP for 2007.

However, at the recent National Quality Forum (NQF) deliberations, all of the measures did not receive approval. At the NQF Technical Advisory Panel deliberations, three measures did not receive a recommendation for approval. At the NQF Ambulatory Care Steering Committee level, 4 measures were passed and 4 measures were not passed. The predominant rationale for disapproval was that these were "basic care" and reflected what nearly all ophthalmologists were doing already. In the Steering Committee's majority opinion, these

measures were not thought to make a significant difference in improving the quality of care.

We provided a response to the NQF Steering Committee for reconsideration of these measures, based on evidence that they did not consider on their conference call. CMS has indicated that they are likely to include all 8 measures in the 2007 Physician Voluntary Reporting Program since NQF review will not be final by CMS's cut off date of January 31st unless NQF concerns are significant.

This reflects the shift in posture on the part of measurement developers and payers over the past several months, while initially very supportive of specialty entry into measure development leading to our early success.

Previously, many of the measures approved reflected process of care measures. Now they are demanding that measures be related to patient outcome and based on stronger evidence. They are no longer satisfied with basic process of care measures.

In addition, the AQA Alliance is involved in defining additional performance measures in 2 areas: appropriateness of care, and costs of care. The AQA Alliance defined the use of appropriateness measures to determine if a proposed treatment or procedure is a reasonable approach to care by consideration of the balance of risk and benefit in the context of available resources for an individual patient with specific clinical characteristics. The AQA Alliance has identified a need for a measure of overall cost per patient per physician, which will require appropriate methods for risk-adjustment, sample size and other factors. The dominant models for cost of care measurement rely on administrative data driven by categorization of episodes of care.

PRESSURE FROM PAYERS FOR MEASURES MORE DIRECTLY RELATED TO OUTCOMES

From the start of convening the Eye Care Workgroup, the AQA Alliance and CMS stated their desire for measures that were related to good outcomes, that would differentiate the doctors (separate the "better" doctors from the others), and/or address issues of appropriateness of care, namely overuse of care. At that time, the payers were focused on the appropriateness of cataract care, with the idea that cataract surgery, a significant procedure under Medicare, was overused and that a measure was needed to address appropriate indications for

cataract surgery, such as a visual functional impairment instrument or visual acuity threshold. Another focus was improving care for patients with primary open-angle glaucoma, because of the significant vision loss in this population.

One of the observers proposed a measure of the actual IOP achieved for each patient. The reasoning given for accountability of an IOP level was that the primary care physician or endocrinologist is already accountable for managing their patients HgA1C or blood pressure to a specific level. We heard from the payers: "We don't really care what the doctor does (e.g., process of care); we care about what happens to the patient." On the day that our starter set of 8 eye care measures passed the AMA Physician Consortium for Performance Improvement, others were already proposing a new generation measure: 20%-30% reduction in IOP in patients with POAG over a year's time, based on Level I evidence that shows that lowering IOP leads to improved outcomes.

PASSAGE OF INITIAL SET OF 8 OPHTHALMOLOGY MEASURES

Over the past several months, the Eye Care Workgroup, was able to address many of the concerns of the AQA and CMS. First, through collated evidence of the literature, they were able to show that cataract surgery is utilized appropriately and the outcomes are excellent. Second, data analysis in one payer's database on the surgical complications of cataract surgery demonstrated that the complication rates were too low to warrant the efforts of measurement by the payers. Third, pointed out that issues of patient compliance and other factors beyond the physician's control complicated the use of an IOP level as an outcome measure. Ultimately, they were able to convince the AQA, NQF and CMS that this was an acceptable "starter set" of measures, that we needed to start with process of care measures, and that these measures would make a difference in quality of care, because of the gaps in utilization that were able to be documented in the literature.

OTHER SPECIALTY MEASURES

The Starter Ambulatory Measure Set approved by AQA for primary care includes many prevention measures—did they receive the appropriate screening or vaccination? Several measures evaluate the prescriptions of appropriate therapies within a certain timeframe, such as beta-blocker treatment or ACE inhibitors, once a patient is diagnosed or identified with the disease. Three primary care measures

directly assess the achievement of an outcome (or measuring the opposite—poor control):

- Blood pressure management: Percentage of patients with diabetes who had their blood pressure documented in the past year less than 140/90 mm Hg.
- HbA1C management control: Percentage of patients with diabetes with most recent A1C level greater than 9.0% (poor control)
- LDL cholesterol level: Percentage of patients with diabetes with most recent LDL-C less than 100 Mg/dL or less than 130 mg/dL

Two measures address overuse or misuse—treatment of children with a URI (measuring those who do not receive antibiotics) and testing of children with pharyngitis (measuring those who receive a group A strep test and antibiotics).

On a recent AQA Alliance call, three payer representatives voted against the AMA Physician Consortium for Performance Improvement (PCPI) measures put forward by the gastroenterologists and the emergency room doctors because of concerns that these did not really correlate to better quality of care and improved outcomes.

Their concerns were that these types of measures being developed by the PCPI are not addressing the needs of payers to have public accountability of doctors and to differentiate what really improves patient outcomes. Even the well-accepted protocol of providing aspirin and beta blockers to patients with an MI was called into question, because of a JAMA article that concluded that adherence to these protocols did not make a significant difference in mortality among hospitals. The study authors recommended that efforts be made to develop performance measures that are tightly linked to patient outcomes.

NEXT STEPS

The Eye Care Workgroup is convening again in early 2007 to develop additional eye care measures, initially focused on primary open-angle glaucoma and cataract. We want to be proactive and anticipate developing measures that are correlated to improved patient outcome. If we don't lead this effort to develop such measures, we will continue to face oddball successions and measures from payers/plans and lose out on bonus money that will only continue to increase. We would invite the subspecialty societies to begin thinking about performance measures that are linked to patient outcomes and would

make a significant difference in how patients fare.

If you have questions about P4P and the AAO's role in collaboration with subspecialty societies, please email your inquiry to flum@aao.org.

AAO Newsroom

Specialty Society Input on Clinical Correspondents

The American Academy of Ophthalmology is compiling a comprehensive 2007-2008 clinical correspondent database for media inquiries. The AAO invites you to submit suggestions for spokespeople in your state or specialty society who are among the best in their area of expertise.

Candidates should be comfortable talking to the media and have the time to respond to requests. If you recommend someone, the AAO will need their name, contact information, society affiliation and curriculum vitae.

The AAO is looking for experts in the following areas:

- Cataract
- Cornea and External Disease
- General Ophthalmology
- Glaucoma
- Low Vision Rehabilitation
- Neuro-Ophthalmology
- Pediatric Ophthalmology
- Refractive Surgery
- Retina
- Uveitis & Intraocular Inflammation

Recommendations are very important, particularly as the Academy prepares to launch a new public education this summer. The Academy's clinical correspondent program helps keep ophthalmology top-of-mind when reporters, editors and producers are seeking information on eye health. It helps spotlight ophthalmologists as the go-to-experts when it comes to eye health information.

Please respond to Adam Matza (amatza@aao.org), media relations manager, by April 2, 2007.

March is Age-Related Macular Degeneration Awareness Month

Age-related macular degeneration (AMD) is the leading cause of visual impairment and blindness in Americans older than 50, affecting more than two million people.

March is AMD Awareness Month, and the AAO wants to remind people that although AMD is incurable, there are new treatments that can usually recover lost vision and prevent further vision loss from the disease.

The Academy encourages those older than 50 to see an ophthalmologist for a comprehensive, dilated eye examination every one to two years to ensure that AMD and other vision-threatening conditions are detected and treated early.

WHAT IS AMD?

AMD, progressive and usually painless, affects the macula, a small, specialized area of the retina, located at the back of the eye and responsible for central vision. AMD causes central vision to blur, but leaves peripheral vision intact.

There are two types of AMD: dry and wet. Approximately 90% of people with AMD have the dry form, in which aging changes in the macula result in gradual vision loss.

Although only 10% of people with AMD have the wet form, it generally progresses much quicker than the dry form. Wet AMD is characterized by the growth of abnormal retinal blood vessels that leak blood or fluid, causing rapid and severe central vision loss.

REDUCING AMD RISK

The most important risk factors for AMD include smoking, high blood pressure and diet. Recommendations for reducing the risk of developing AMD include not smoking; eating a heart-healthy diet rich in fish, fruit and green leafy vegetables; avoiding foods with trans fats; exercising and controlling your blood pressure and weight.

Other risk reducers include:

- The National Eye Institute's Age-Related Eye Disease Study found that high levels of antioxidants and zinc can reduce the risk of vision loss by about 25% in patients with "intermediate" AMD in one or both eyes and those with "advanced" AMD in only one eye. (Smokers and ex-smokers should not use beta

carotene because studies have shown an association with lung cancer and beta carotene in smokers.) A new study will evaluate the effects of lutein and omega-3 fatty acids.

- Anti-Vascular Endothelial Growth Factor (VEGF) drugs inhibit the development of unwanted blood vessels that cause wet AMD, and these agents help prevent further visual loss and even improve vision. At the current time, these are injected directly into the eye. Two drugs have already been approved by the FDA, Macugen and Lucentis, and the makers of several others are looking to gain FDA approval.
- Conventional laser therapy and photodynamic therapy are also treatments of wet AMD and have been approved by the FDA based on studies by the National Eye Institute.

To locate vision rehabilitation services in your area, call Vision Connection at 800-829-0500 or go to Help Near Year at www.visionconnection.org.

AAO-HNS

Update

Head and Neck Cancer Patients Improve Their Quality of Life Through Support Groups

Efforts to improve the quality of life in patients recovering from head and neck cancer would be vastly improved by participation in support group activities, according to a new study published in the March 2007 issue of *Otolaryngology-Head and Neck Surgery*.

The study, which administered quality-of-life (QOL) surveys to 47 patients who had previously undergone treatment for head and neck cancer, determined that support group participants experienced scores significantly better in the areas of eating, emotion, and pain, compared with participants who did not attend support groups. As a result of these findings, the study's authors suggest that support

group therapy should be included in regular therapy for head and neck cancer patients.

The study's authors administered the *University of Michigan Head and Neck Quality of Life* survey, which covers four different categories: head and neck pain, eating and swallowing, communication, and emotional well being. Participants in the support group took part in hour-and-a-half long biweekly multidisciplinary sessions over the course of a year.

Hearing Loss in Children Leads to Substantial Meningitis Risk

Children who are stricken with severe hearing loss are five times more likely to contract meningitis, according to a new study published in the March 2007 edition of *Otolaryngology-Head and Neck Surgery*.

The study, conducted over a nine year period, monitored 663,963 children born in Denmark between 1995 and 2004. It identified 39 children with both hearing loss and meningitis; of these children, five were first diagnosed with hearing loss, and later, meningitis. Statistically, the authors determined the likelihood of a child developing meningitis after losing their hearing is five times that of other children; their research indicates that factor could in fact be as high as 12 times that of other children.

The study's authors say their research provides evidence of an association of hearing loss and the onset of meningitis, providing physicians and parents with ample reason to be mindful of possible signs and symptoms of meningitis, and allowing for vaccination to be considered as a preventive step.

Previous research by the Centers for Disease Control and Prevention determined that children who receive cochlear implants to counter hearing loss are more likely to develop meningitis. Worldwide, 90 of the 60,000 people receiving cochlear implant have been stricken with meningitis, drawing particular concern within the medical community.

Job Advertisement AOCOO-HNS Executive Vice President (CEO)

The American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery is seeking an experienced and dynamic physician-leader to serve as the Executive Vice-President (CEO) for the AOCOO-HNS Board of Governors. This would entail a period of time serving in a mentorship program with the current EVP prior to assuming the position.

The principal responsibilities of the position include:

- Overseeing staff employees
- Carrying out administrative work of the corporation
- Establishment of administrative policies
- Implement directives of the Board
- Coordinate meetings and activities of the Board
- Prepare annual budgets and review all financial activities
- Maintain fiscal responsibility of all Colleges' activities
- Maintain close working relationships with the AOA and activities of the Colleges'
- Serve, together with the President, as spokesperson for the Colleges' and Foundation
- Maintain the legal integrity of the Corporation
- Work with the Boards to plan meetings and develop strategies and agendas
- Attend all College associated meetings with the AOA as needed
- Perform all on-site inspections of proposed meeting locations.

Interested candidates should have a working knowledge of the AOA and in particular, the workings of the Bureau of Education, its committees, and the AOA Board of Trustees.

Please request an application form, which is to be sent together with your current CV to Carlo DiMarco, DO, c/o AOCOO-HNS at 4764 Fishburg Road, Suite F, Huber Heights, OH 45424.

Direct all inquiries in writing to the Search Committee Chairman, Carlo DiMarco, DO at the address listed above.

Ophthalmology Opportunities

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@nveypa.com or 702-492-6928.

OHIO

- 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 Figs 509-952-8545.

Equipment for Sale

SLT Selecta II - LUMENIS laser - Selective Laser Trabeculoplasty - single owner - great laser for the comprehensive ophthalmologist - EXCELLENT Condition!! SLT is much more comfortable than the ALT, and is repeatable!! Great for non-compliant patients, those with drug allergies, or patients who want freedom from gtts!! Complete with carrying cases, mirror, gonioscopes, USED!! Asking 45K. All reasonable offers considered! (New lasers currently go for 65K + shipping + several months wait!)
jameskao@aol.com or 213-798-0721.

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: platinum@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.

NEW JERSEY

- Three man group in Brick, NJ has need to add a fourth surgeon. Practice all aspects of Allergy, Pediatric ENT, Hearing and Balance. Call is currently 1:3. Located on the Jersey Shore, one hour from Philadelphia. Apply by letter to: Thomas E. Brandeisky, DO, 208 Jack Martin Blvd., Building C, Brick, NJ 08725 or call 732-458-8575.

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.
- 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 perryent@ssnet.com.

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.