

Resident's Monthly Newsletter

Volume 4, Issue 2

June, 2011

President's Blog, June 2011

As the month of June comes to an end, it becomes an exciting time for residents and fellows who will be finishing their academic training programs. I wish everyone who is graduating success in the years to come. I encourage the graduates to stay active in the AOCOO-HNS and hope you will return as members of the Colleges. Academic programs and CME are available at the Mid-Year meeting, the Annual Faculty Development Meeting, and the Annual Clinical Assembly of the AOCOO-HNS. This is also the time for junior residents to "step up to the plate" and become the new senior residents. Sharing your knowledge and skills with those residents behind you improves the quality of medicine for all who participate. Ultimately, this will lead to improved patient care and better outcomes.

Best Wishes,

David D. Gossage, DO, FAOCO

President of the AOCOO-HNS and Foundation

2011 YEAR-END REPORT REMINDER

The AOCOO-HNS Council of Medical Education meeting is being held on Thursday, August 25, 2011. At this meeting, the Council reviews resident files that are inclusive of all year-end reporting requirements. The AOA requires that year-end reports be submitted to the Specialty College no later than 30 days following the completion of each training year. **The AOCOO-HNS will accept year-end reports POSTMARKED through July 30th. Any reports that are received after August 1st will be reviewed at the February 2012 Council meeting.**

COPIES OF YOUR ANNUAL REPORTS. The AOA requires that all training institutions keep on file copies of year-end reports. The College Office has been contacted by numerous DMEs requesting copies of year-end reports. It is the responsibility of the program director and resident to make sure that the training institutions/DMEs receive their required copies. The College has also been contacted by residents requesting copies of year-end reports. We recommend that all residents take the time to make copies of year-end reporting forms and file them away for future credentialing use.

CRF Report, June 2011

It's time to get geared up for another academic year. Let's begin by wishing those graduating the best as they enter into fellowship and practice. Thank you for your leadership and contributions to the College. Remember to stay involved in any way you can. It is more important now, than ever before, that we not only stay informed, but involved in the political arena, especially in healthcare. The AOCOO-HNS is a great way to stay in touch.

In putting together a research project, I came across this article titled "The Osteopathic Aspect of Ophthalmology and Otorhinolaryngology" published in 1947. We thought it would be a good idea to include this article in full in the June newsletter and I think it serves as a good reminder of our purpose and an interesting perspective. Are things different now than they were in 1947? Are there some similarities? The take home points from this article for us today are: (1) we have come quite a long way from the way things were in 1947, (2) don't forget your training and (3) BE A PART OF THE AOCOO-HNS and help to keep our future bright!!

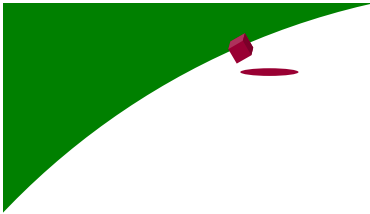
Let's have a good year and remember to keep in touch with the College. A great way to do that is through us, the Council of Residents and Fellows! Contact us anytime. We are your voice to the College.

We are also always looking for articles, opinions, maybe an interesting case or educational resources that may help other residents that can be included in the *Resident Newsletter*. Have something to say? Send it to us! See you next month.

Matthew D. Lowrance, DO
Ophthalmology Chair, CRF

Ryan C. Palmer, DO
Otolaryngology Chair, CRF





2011 Resident Award Recipients

Patrick Murray Awards

Ophthalmology

- ◆ 1st Place-William I. Sawyer, DO, Grandview Hospital and Medical Center
- ◆ 2nd Place-Karen E. Dickes, DO, Grandview Hospital and Medical Center
- ◆ 3rd Place-Christiane K. Hunt, DO, Grandview Hospital and Medical Center

Otolaryngology/Facial Plastic Surgery

- ◆ 1st Place-Daniel F. Boxwell, DO, Pontiac Osteopathic Hospital
- ◆ 2nd Place-Andrew N. Stevenson, DO, Doctors Hospital
- ◆ 3rd Place-Jordan J.T. Mulder, DO, Des Peres Hospital
- ◆ 3rd Place-Nicholas Purdy, DO, St. Barnabas Medical Center
- ◆ 3rd Place-Adam C. Rourke, DO, Pontiac Osteopathic Hospital

AOCO0-HNS Resident Monthly Newsletter

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Otolaryngology-
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Resident Monthly Newsletter are not
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American Osteopathic Colleges of
Ophthalmology and Otolaryngology-
Head and Neck Surgery.

We're on the Web!
www.aocoohns.org

Resident Professional Paper Awards

Ophthalmology

- ◆ 1st Place-Joanna P. Wahl, DO, Metro Health Hospital, "The Validity of Computed Tomography in an Acute Presentation of Symptoms of Decreased Vision".
- ◆ 2nd Place-Karen E. Dickes, DO, Grandview Hospital and Medical Center, "Long-Term Rotational Stability of the Alcon AcrySof Toric Intraocular Lenses".
- ◆ 3rd Place-William I. Sawyer, DO, Grandview Hospital and Medical Center, "Use of the Boston Type I Keratoprosthesis and Silicone Oil in the Treatment of Hypotony in Prephthisis".

Otolaryngology/Facial Plastic Surgery

- ◆ 1st Place-Azeem Z. Vasi, DO, Grandview Hospital and Medical Center, "Single-Stage Reconstruction of a Large Full-Thickness Scalp Defect with Anterior and Posterior Bipedicled Scalp Rotational Flaps".
- ◆ 2nd Place-Justin L. Elder, DO, NYCOM/St. Barnabas Medical Center, "Endoscopic Repair of Nasal Septal Perforation with Turbinate Free Graft".
- ◆ 3rd Place-Kimberly R. Ostrowski, DO, Pontiac Osteopathic Hospital, "Benign Symmetric Lipomatosis of the SYpraglottic Larynx: A Rare Cause of Dysphonia".

Resident Poster Awards

Ophthalmology

- ◆ 1st Place-Matthew D. Lowrance, DO, Hillsdale Community Health Center, "A Quantitative Measure of the Effects of Eyelid Massage on the Production of Tears and a Proposed Osteopathic Treatment Technique for Dry Eyes".
- ◆ 2nd Place-Erin Benjamin, DO, Hillsdale Community Health Center, "A Conjunctival Optical Coherence Tomography as a New Technique in Giant Papillary Conjunctivitis Assessment and Correlated Treatment".
- ◆ 2nd Place-Joanna P. Wahl, DO, Metro Health Hospital, "The Validity of Computed Tomography in an Acute Presentation of Symptoms of Decreased Vision".
- ◆ 3rd Place-Hal Schwartzstein, DO, St. John's Episcopal Hospital, "Complications Following Plaque Radiotherapy of Small Posterior Uveal Melanoma in 1,524 Cases".

Otolaryngology/Facial Plastic Surgery

- ◆ 1st Place-Shaunda M. Rodriguez, DO, Millcreek Community Hospital, "Use of Serum Parathyroid Hormone Levels After Near Total and Total Thyroidectomy in the Community Hospital Setting".
- ◆ 2nd Place-Jason T. Stubbs, DO, Freeman-Oak Hill Health Systems, "Alveolar Soft Part Sarcoma of the Scalp".
- ◆ 3rd Place-Scott M. McClintick, DO, Fellow, University of Iowa Hospital, "Health Care Utilization in Patients with Head and Neck Cancer".

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September, 1947

The Osteopathic Aspect of Ophthalmology and Otorhinolaryngology*

A. C. HARDY, D.O., F.O.C.O.
Kirksville, Mo.

The osteopathic concept in relation to the practice of the various specialties is a matter of vital concern to the osteopathic profession. In the interest of professional consistency, and, as we believe, of greater efficiency, it is important for us to know that every specialty group, and every individual in the group, entrusted with the care of patients not only is osteopathic minded, but also is keeping foremost in his thinking and in his practice the fundamental osteopathic principles in relation to the cause and cure of disease.

It would seem altogether proper for each of our specialty groups to be required periodically to give before the American Osteopathic Association an accounting of its osteopathic stewardship; this for its own good, as well as to assure the Association that its specialists are loyal to the fundamental principle of osteopathy, and are giving to our patients the benefits of structural analysis and structural correction in connection with the service they render. The Osteopathic College of Ophthalmology and Otorhinolaryngology welcomes the opportunity to discuss this important phase of its activity.

The history of osteopathic ophthalmology and otorhinolaryngology now covers a period of half a century. Its modest beginning was early in the history of the profession, when a few pioneer osteopathic physicians who possessed, or were able to obtain, specialized training in these subjects, chose to devote themselves to the practice of ophthalmology and otorhinolaryngology in connection with osteopathic practice. These men, who were teachers and leaders in the profession, and I should say possessed with the vital spark of original thinking, undying energy, and unselfish devotion to the task at hand, undertook the ambitious program of remodeling the oldest and best standardized specialty in medicine to meet the needs of a new and advancing system of therapy. This required the modification of many procedures, the total elimination of some, the addition of others; and the gradual adoption over a period of years of technics developed through osteopathic research—all with the aim of conforming more closely to natural

laws, to conserving structure and nature's healing powers, and to allow for the hitherto unknown benefits derived from structural corrective work. The result today is a system of ophthalmology and otorhinolaryngology which is unique in many essential details, and which well justifies the qualifying term "osteopathic ophthalmology and otorhinolaryngology."

The organization history of this group is well known to most of you, and yet there has been a good deal of confusion at times over what appeared to be a multiplicity of organizations, assumed by some to be factional groups. Through the years we have had the eye, ear, nose, and throat section of the American Osteopathic Association, the American Osteopathic Society of Ophthalmology and Otolaryngology, the International Society of Osteopathic Ophthalmology and Otolaryngology, and finally the present organization, the Osteopathic College of Ophthalmology and Otorhinolaryngology. Each of these organizations has served, in fact, a very definite purpose in the expansion and growth of our profession, and each succeeding organization has constituted a step forward in educational facilities, and in professional service.

The eye, ear, nose, and throat section of this Association, organized early in our professional history, exists today as a teaching session, and each year since its organization has prepared and presented an educational program at the national convention of the A.O.A. The American Osteopathic Society of Ophthalmology and Otolaryngology, organized in 1916, was formed in response to an urgent demand for more extensive programs, and more clinics and demonstrations than could be provided through the E.E.N.T. section. This organization published the *Journal of Osteopathic Ophthalmology, Rhinology and Otolaryngology*, and through it contributed much to osteopathic literature.

These early organizations were open to any member of the American Osteopathic Association, the only requirements for membership being graduation from an approved osteopathic college, membership in the American Osteopathic Association, and good professional standing.

The International Society of Osteopathic Ophthalmology and Otolaryngology, organized in 1930, con-

*Delivered before the General Sessions at the Fifty-First Annual Convention of the American Osteopathic Association, Chicago, July 23, 1947.

sisted solely of specialists in these branches who limited their work definitely to ophthalmology or otorhinolaryngology or both. It was organized for the purpose of advanced study, highly technical programs, research, and for a cooperative effort to standardize specialty training and specialty practice; to provide greater opportunity for postgraduate training in these branches; and to extend recognition, or certification, to those who could meet the rigid requirements of the organization. Membership in the organization was obtained only by examination, written, oral, and clinical, after the applicant had shown evidence of adequate and acceptable training and experience. Thus the International Society pioneered in the osteopathic profession in standardizing and certifying specialists, and provided the pattern utilized today by the Advisory Board for Osteopathic Specialists in the setting up of specialty boards for the examination and certification of specialists in all branches.

The Osteopathic College of Ophthalmology and Otorhinolaryngology which was organized in 1944, represents a coalition of all these prior organizations, except the E.E.N.T. section. It assumed the functions of all, and provides an associate group, for purposes of professional education, and a classified membership which consists of Juniors, Seniors, and Fellows. To become a Junior one must have had a minimum of acceptable training as prescribed, a stated amount of actual experience, and must have submitted and had approved fifteen acceptable case reports. To be a Senior, one must devote himself exclusively to the specialty, must be certified in this specialty by the American Osteopathic Association, must have submitted and had approved twenty-five case reports, of a major and varied character, and must be acceptable to the organization. Fellows are elected for outstanding service to science and to the profession.

To understand and appreciate the true relationship between this specialty and osteopathy, we should consider five basic premises which I hope to establish in this discussion:

First, every osteopathic ophthalmologist and otorhinolaryngologist is primarily an osteopathic physician, and often with years of prior experience in general practice. He has a good understanding of osteopathic problems, a full appreciation of osteopathic therapy which has previously been administered, or is to follow, in the management of patients in his charge.

Second, as an osteopathic physician, he is by nature and training conservative. He has a profound faith in the healing powers of nature when unimpeded by structural derangement. He believes in a minimum of surgery, conservative rather than radical surgery whenever possible; fewer drugs, more diet, hygiene, and other natural means.

Third, the osteopathic ophthalmologist and otorhinolaryngologist utilizes osteopathy to the fullest possible extent in connection with his practice, preferring always to have the actual manipulative treatment administered by others, but, on occasion when that is impossible, may actually administer the treatment himself.

Fourth, that osteopathy has made a substantial contribution to ophthalmology and otorhinolaryngology through the added benefits of osteopathic principles and practice, thus creating a system of practice which is unique, and in many respects is superior to that practiced by other schools of thought.

Fifth, ophthalmology and otorhinolaryngology has made an equally valuable contribution to osteopathy in greatly broadening its scope of service, and enhancing materially the already excellent results obtained by general osteopathy, and those by osteopathic specialists in other branches.

The first two of these premises need not be elaborated, since the facts are self-evident. Their importance, however, will be fully appreciated by those of you who have been forced by circumstances to rely upon unsympathetic consultation in the management of specialty cases. The third premise, which concerns the actual use of osteopathy in specialty practice may well receive some considerable attention.

In order to give adequate support to this premise, and to avoid the mere expression of personal opinions, and practices, we mailed questionnaires to all the members of the Board of Governors of the Osteopathic College of Ophthalmology and Otorhinolaryngology, and to a few others among our leading specialists, asking for information to be incorporated in this discussion. We received a very satisfactory response, and much valuable information, all of which we would like to quote if time would permit. It has been interesting to observe the remarkable uniformity of opinions and practices indicated in these replies, indicating an unusual unanimity of thought regarding basic principles and purposes.

One hundred per cent of these replies expressed a profound faith in the fundamental principles of osteopathy, and each felt that structural corrective work was just as important in ear, eye, nose, and throat cases as in general body disease. With but one exception, each stated emphatically that he uses osteopathy routinely in his practice. Dr. L. S. Larimore, of Kansas City, says: "I examine the cervical and upper dorsal for lesions and contractions, and treat same in at least 75 per cent of patients examined and treated." Dr. T. J. Ruddy, of Los Angeles, makes this statement: "I am sincere when I say that in every instance of surgical operation on the ear, nose, throat and eye, and also in every pathology of these organs that I've treated non-surgically, there is a definite improvement in kind, time, and comfort, through correction of undue tension and pressure in the cervical and upper dorsal regions resulting from the pathology, if not the cause of it primarily."

Dr. Edward W. Davidson, of Los Angeles, deals more specifically with the problem in these words: "(a) In the postoperative care of tonsillectomies, osteopathic manipulation of the neck definitely decreases the postoperative soreness and discomfort. (b) At mastoid surgery, it is common for the patient to lie with his head turned far to one side for a period of from 30-minutes to 2½ hours. This frequently develops a structural lesion in the neck which adds to the patient's postoperative discomfort. I make it a practice to mobilize the neck in the opposite direction at the close of surgery, and have been gratified with the result. (c) I have had a considerable number of patients referred to me because of earache, which turned out to be an atlanto-occipital lesion, which caused pain so close to the ear that the patient described it as earache. The pain is relieved by osteopathic correction, and that is the only logical way to treat the condition. (d) I have found that nasal obstruction caused by swelling of the mucosa may frequently be relieved by manipulation as effectively as by astringent

drugs, and without the later deleterious effects. . . . (e) Not infrequently a patient has found definite and permanent relief from eyestrain after the correction of cervical and upper dorsal lesions. (f) I think there are many cases of glaucoma which do better with osteopathic treatment included in their therapy. (g) I have known one case in which marked crossed eyes were caused by a cervical lesion, were corrected by the correction of the lesion, and would remain corrected so long as the lesion did not recur." Also, in a paper† on sinusitis Dr. Davidson makes this significant assertion: "I make no sweeping statement that osteopathic manipulative treatment is all that is necessary to cure sinusitis. But I have seen chronic sinus infection which resisted every specific treatment I could bring to bear, promptly begin to improve when the general body structure received intelligent attention."

Dr. R. S. Licklider, of Columbus, Ohio, makes the point that much of our surgery consists of the correction of faulty body mechanics, and is distinctly osteopathic in principle. He cites the submucous resection of the nasal septum, in which the surgeon corrects a faulty structure which has impaired function, and has produced disease, a procedure no less osteopathic than the correction of a spinal joint lesion.

We are indebted, also, to Drs. C. C. Reid, L. A. Lydic, Lloyd L. Seyfried, and others for valuable contributions, which we have not been able to use without undue repetition.

We had confidently expected some of our contributors to comment upon the value of osteopathic therapy as preparation for surgery, and as a specific benefit in the postoperative care of surgical cases. Since they have not done so, we must quote from our own records. In the ear, eye, nose, and throat departments of the Kirksville College of Osteopathy and Surgery and the Laughlin Hospital, we have always made a point of osteopathic manipulative treatment, if possible, before surgery, but always as after-treatment, requiring that every patient receive one or more treatments daily. We believe this not only adds to the patient's comfort, but also materially aids the healing of wounds, assists in preventing complications, and improves our total results.

During the 27 years of our tenure with these hospitals the writer and his immediate associates have performed over 10,000 surgical operations in the ear,

†Davidson, E. W.: A resume of treatment of sinusitis. *J. Am. Osteop. A.* 45:413-417, May 1946.

eye, nose, and throat field. This has included a high percentage of acute and emergency practice, cases which could not be chosen on the basis of surgical promise, but sometimes had to be operated because surgery offered the only chance for life. Cases ranged from the most minor to the most complicated major problems, and the patients were operated under various types of anesthesia, both local and general.

During this time the mortality rate was 0.1 per cent; there was just one case of anesthesia pneumonia, and the patient recovered. There was not a single case of postoperative pulmonary abscess, to our knowledge. In ophthalmic surgery we had our share of losses from operative accidents, hemorrhages, etc., but not a single eye operated was lost from infection, or from post-operative glaucoma.

If these records are better than average, the credit most certainly is due to osteopathic management of cases, since we make no claims to superior surgical ability, or to unusual therapeutic skill.

In conclusion we would like to say first, that after 39 years devoted to the study and practice of osteopathy, first in general, then in specialty practice, we are firmly convinced that there is no pathology in our special field, or in the general field, which is not made materially worse by the existence of certain structural lesions; and that there are few which cannot be materially helped by the intelligent application of structural correction.

And second, a full and complete osteopathic service can be rendered only by a close and continuous co-operation between general practitioner and specialist. Your specialist who has a valuable, and often indispensable service to render to your patients, and who we hope is well trained for the task, will be the first to recognize the limitations of specialty practice in the presence of faulty body mechanics, or of uncorrected systemic pathology. He deplors the all too frequent tendency of the referring physician to dismiss immediately the case he finds is in need of a specialist's service, when continued osteopathic manipulative treatment would be very helpful, and would certainly be welcomed by the specialist in charge. Except for those intervals, usually short, when the nature of the case precludes manipulative therapy, we would urge that whenever possible the general practitioner maintain contact with his specialty cases, and continue to treat them osteopathically, to secure the best and most speedy results.

K.C.O.S. Hospital.

SURGEONS, RADIOLOGISTS, HOSPITAL ADMINISTRATORS MEET IN LOS ANGELES NEXT MONTH

Last minute preparations are being rushed for the twentieth Annual Conclave of the American College of Osteopathic Surgeons to be held in the Biltmore Hotel, Los Angeles, October 19 to 23.

Dr. K. Grosvenor Bailey is general conclave chairman; Dr. Lucius B. Faires in charge of program activities; Dr. J. Willoughby Howe activates the entertainment; Dr. Troy L. McHenry, President of the Osteopathic Surgical Society of Los Angeles, the host group, serves as coordinator; Dr. H. B. K. Willis is public relations chairman, with Harry Hammond Beall as director of publicity.

The actual program of the American College of Osteopathic Surgeons does not start until Monday, October 20. The American Osteopathic Hospital Association and the American Osteopathic College of Radiology, which are holding concurrent conventions, will launch their activities on Sunday, October 19, the date when registration of American College of Osteopathic Surgeons is scheduled.

On Monday night, October 20, the Conclave and Biltmore Banquet will take place in the Biltmore Bowl.

Dr. H. Willard Sterrett, of Philadelphia, current president of the American College of Osteopathic Surgeons, will surrender the gavel during the conclave to President-elect Dr. Edward T. Abbott of Los Angeles.

The American Osteopathic Board of Surgery will conduct sessions to examine applicants seeking certificates for surgical specialties.

Approximately 500 members of the college are expected from all over the nation. Many national problems will be considered. California surgeons will demonstrate their latest technic to eastern delegates, with special clinics to be held in the osteopathic hospitals of metropolitan Los Angeles.

Outstanding public health officials will attend, as well as leaders from osteopathic colleges of the country, including Kansas City, Philadelphia, Chicago, Des Moines, Los Angeles and Kirksville, Mo.