american rhinologic society
nose news

NOSE NEWS NOVEMBER 2014

TABLE OF CONTENTS

COSM PROGRAM CHAIR UPDATE

Peter Hwang, MD
President Elect and Program Chair

With the ARS at AAO meeting recently wrapping up with our biggest turnout ever, we look forward to the spring meeting with even greater enthusiasm. Next spring's ARS at COSM scientific meeting promises to offer a stellar showcase of the best of contemporary rhinology. The meeting will be held April 23-24, 2015 at the Hynes Convention Center in Boston, Massachusetts. Look for interdisciplinary panels with our sister societies, expert panels, "great debates," and the very best of cutting edge rhinology research. The deadline for on-line abstract submission is January 16, 2015. Research awards will be given to the best clinical and basic science research papers presented at the spring meeting.

Registration for the ARS at COSM meeting opens online in January 2015. Go to the ARS website or the COSM website for complete information on meeting registration, hotel accommodations, and abstract submission.

See you in Boston!

Back to top

PRESIDENT'S REPORT

Roy Casiano, MD, FACS

It's been a banner year for the American Rhinologic Society (ARS). Under Tim Smith's leadership, we saw a lot of firsts in 2014. The Society has continued to attract general otolaryngologists, academic rhinologists, and industry partners, through its many innovative educational venues and cutting-edge research. Today's ARS is truly an uncontested world leader in the field of rhinology and endoscopic skull base surgery. Our spring meeting (ARS at COSM), Summer Sinus Symposium (SSS), and fall meeting (ARS at AAO-HNS), all saw record attendance this year. With the leadership of Kevin Welch, Rick Chandra and Jim Palmer, the SSS has become one of our most successful new educational venues. The highly interactive format of the SSS has become a very popular venue for general otolaryngologists who see patients with common rhinologic complaints, as well as for our industry partners. The fall meeting saw almost 600 attendees who celebrated the 60th anniversary of the ARS. This year's guest countries (Mexico, Brazil, Venezuela, and Colombia) turned out in force at the Orlando meeting, registering over 100 participants. Including our international registrants, we had over 200 first time attendees.

The board also approved the implementation of new ideas to enhance the value of ARS membership to national and international otolaryngologists. Starting in 2015, the SSS will be free for paid members. This year, with the support of our industry partners (Medtronic, Acclarent, TEVA, Meda Pharmaceuticals, Intersect, and Olympus), we also introduced very successful, and well attended, satellite symposia and hands-on cadaver dissection labs at both the SSS and fall meetings. We hope to build on these successes for next year's meetings. We have also collaborated with colleagues in other sister societies. The annual AAOA/ARS combined panel at the fall meeting was a success. Next year we will also be exploring similar combined panels with the North

American Skull Base Society (NASBS). As new program chair and president-elect, Peter Hwang will undoubtedly have his hands full. However, I have no doubt that Peter will do a superb job.

There has been a significant increase in applications from residents, fellows, and otolaryngologists (community and academic), for committee participation in the ARS. This year there were over 60 online applications submitted for committee participation, and almost all were accommodated with their first or second choices. As 1st Vice President and Chair of the Committee on Committees, John Delgaudio, along with Joe Jacobs, have been charged with refining this process further in 2015. They are actively working with the chairs to define the committee goals, as well as to engage committee members to more effectively achieve their goals. The board also approved expanding our current 1-day Saturday meeting in the fall to one and a half days by including a half-day session on Friday. This will go into effect at our next fall meeting in Dallas in 2015.

Our corporate support has remained at an all time high due to the diligent work of our new Executive Vice President Joe Jacobs, Susan Arias, and others in the Development Committee. We all agree that corporate support has become an invaluable financial resource, allowing the ARS to fulfill its teaching and research mission to members and patients. We thank all of our corporate partners for their continued support in the future.

Our “Friends in Research” initiative continues to move forward with donations from the ARS leadership. I’d like to thank all of you that have supported these efforts. Your generosity has not gone unnoticed. If you haven’t contributed to this initiative, please consider making a donation. Also, invite a colleague to do so as well. Without these donations, and our unrestricted corporate support, it would be impossible to provide the type of research and educational programs we are currently able to provide.

Our Fellowship Directors’ Committee, under the direction of Todd Kingdom, reports that fellowship applications are at an all time high, with 55 applications submitted for 24 positions in the 2015 academic year. This presents both an opportunity, but also a challenge as we move forward in the future. However, all the programs are doing a great job preparing our next generation of rhinologists. This year we engaged all program directors to reach a consensus in a standardized fellows’ case reporting format. Rick Chandra and his ad-hoc subcommittee developed a case-reporting format that will hopefully be embraced by all programs, and become a helpful piece of information for our resident applicants, as well as for the ARS.

The official journal of the ARS, International Forum of Allergy and Rhinology (IFAR), has also had a banner year, ranking 4th place out of all otolaryngology journals, after achieving an impact factor of almost 2.40. This is a tribute to all our young physician scientists who are constantly striving to be at the cutting edge of research and innovation. I have no doubt that the future of the Society is very bright and in good hands.

Finally, I want to thank all of the board members, committee chairs, and committee members, for all their hard work and commitment to the ARS. It truly has been a team effort. I have no doubt that together we can make 2015 another great year!

Back to top

RHINOLOGY PERSPECTIVES: APPROACHING THE SMELL-LOSS PATIENT

Eric Holbrook, MD

It's 2:00 pm and your clinic is overbooked. You are an hour behind, and your nurse informs you that the next patient is here for smell loss. Does this make you cringe? Chances are that you have seen, or will see, a patient complaining of smell loss. It has been estimated that 19% of the population over the age of 20 and 25% of the population over the age of 53 have a smell disorder. Having a set plan of action before the visit can minimize anxiety and improve patient satisfaction.

Take an extra minute to obtain a detailed history
This is by far the most important part of your evaluation of a patient with smell loss. Find out the degree of loss—partial or complete? Ask about the onset—sudden or gradual? What changes have taken place since the loss was first noticed? A partial loss with perception of improvement predicts a better outcome than a complete loss sustained over a year. Identify events that took place when it first occurred such as a blow to the head, a URI, or changes in medications. The most common identified reasons for loss of smell often have specific associating factors that can be elicited in the history.

Sinonasal Inflammatory Disease

- Occurs in 28% of CRS patients
- Fluctuating loss (pathognomonic)
- Can be gradual
- Improves with systemic steroids
- May evolve to permanent loss with time

Upper Respiratory Tract Infection Related

- Likely viral cause
- Sudden onset
- More often hyposmia than anosmia
- Recovery 32-67%

Head Trauma

- Sudden onset
- Not always correlated with severity of trauma
- Often with smell distortion
- Recovery 10-35%

Age Related

- Gradual onset
- Typically occurs after 60-65
- Variable severity
- Often un-noticed by patients
- Independent of neurodegenerative disorders (inquire about memory/cognition)

Idiopathic (unfortunately very common)

- Gradual onset
- Smell loss severity outside the norm for age
- Commonly hyposmia, but variable
- No surrounding events

Physical exam and testing
A complete head and neck exam with additional attention to cranial nerves is necessary. Localizing neurologic findings may point to a potential mass, and global neurologic findings may suggest a neurodegenerative problem. Nasal endoscopy is essential for identifying infection, chronic inflammatory disease, or a nasal mass. Smell testing is extremely useful for evaluating the degree of smell loss and how the loss relates to population averages for a given age group. The commonly used, self-administered, Smell Identification Test (Sensonics) is a validated and easy-to-use test that the patient can take while you catch up with other patients. Age comparison scores can be obtained. The test should be given prior to nasal endoscopy to avoid effects of mucosal edema or anesthetic on outcomes.

When do I order a CT or MRI?
Although routine MRI imaging for all patients with smell loss has been suggested, diagnosing intracranial masses is uncommon. When a cause of the smell loss has been determined and no neurologic symptoms/signs are identified, MRI is of little value. It becomes more helpful in cases of idiopathic loss, unusual presentations, suspicion of a mass, or congenital loss in the pediatric population (Kallmann's Syndrome). A CT without contrast is useful for suspicion of inflammatory disease, and with contrast when there is a potential central cause.

Your role as a counselor
In most cases (other than CRS) your patients already realize there is no good therapy available. Your role is to be sympathetic,

explain the problem, rule out central lesions, and relieve anxiety. Always remember to review hazards associated with smell loss including inability to smell smoke, natural gas leaks, and spoiled food.

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Back to top

PAST PRESIDENT'S REPORT

Tim L. Smith, MD, MPH

What a year!

I recently completed my term as President of the American Rhinologic Society. What a year! I must first to say that it was a great honor to serve and was a highlight of my career thus far. Thank you.

I learned a great deal during the course of the year. I learned that the ARS is made up of individuals who come from all different practice types and settings. A minority are full-time rhinologists while the majority practice rhinology, allergy, and sinus surgery as some portion of a larger practice. What we all have in common is an interest in learning from our peers and advancing the specialty wherever we can.

This is notable since I have encountered many general and community-based ENTs who believe that the ARS is composed of only fellowship-trained rhinologists. This group, in fact, represents a small minority of the entire ARS.

In the challenging healthcare environment we face, it is extremely important that our patients with nasal, sinus and skull base disease have a voice. There are several factors working against us in this regard. Our entire specialty of otolaryngology-head and neck surgery is small in comparison to other specialties- strike one! There are 5500 otolaryngologists performing sinus surgery in the US yet only 1000 are members of the ARS-we are disorganized- strike two!

Rhinology, allergy, and sinus surgery are in many ways at the core of our entire specialty. Our patients deserve a voice and we should be their advocates. Please consider joining the ARS! Increase our voice and help improve our sub-specialty. Please talk with your colleagues and tell them about our Society and the benefits of membership. I'll see you at a meeting soon!

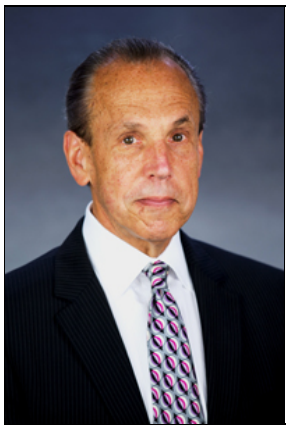
Back to top

ARS ANNOUNCEMNETS: EVP ANNOUNCEMENT AND FRIENDS IN RESEARCH

THE ARS NAMES JOE JACOBS, MD AS EXECUTIVE VICE PRESIDENT

The rapid growth of the American Rhinologic Society and the associated programmatic development has necessitated more and more oversight, communication, and diligence. About nine months ago, the Board of Directors voted to search for an Executive Vice President for the Society. The position was created to assist in providing leadership continuity, communication, and focused execution of our various initiatives.

I was honored to serve as chair of the search committee, which included Mickey Stewart, Rod Schlosser, Sarah Wise, Todd Kingdom, Rick Chandra, and Wendi Perez.



A call for applications was sent to our general membership and finalists for the position were selected and interviewed at the July ARS Summer Sinus Symposium (The Best Sinus Course in the World)! The search committee recently presented our selected candidate to the Board of Directors who unanimously approved the candidate.

I am very pleased to report that **Joe Jacobs, MD** has been selected as the first **Executive Vice President of the American Rhinologic Society**. Joe is well known to all of us having served as a committee chair, member of the Board of Directors, member of the Executive Committee, Treasurer, and Past President of our Society. Most recently, he has directed our Corporate Partners program, which has been extremely successful in reengaging these critical partners.

Please join me in welcoming Joe to this new and exciting position.

Here's to a new era for the American Rhinologic Society!

My best to you all,

Tim L. Smith, MD, MPH
Past President, ARS

Friends in Research Campaign

We want to express our sincere thanks for the generous donations to the ***2014 ARS Friends in Research Campaign***. With your support, we can continue to fund the studies that provide clinical insights valuable to the care of our patients. In the past, these efforts have helped to establish the ARS and its members as the leaders in rhinologic research. This work not only advances the care of our patients through scientific innovation, but also generates important data establishing the efficacy and cost effectiveness of our care. In the current financial landscape, this is equally important to ensure that our patients have access to the treatment necessary to address their complaints.

Platinum Friends in Research for 2014 will be invited to a special reception with ARS leadership at the Fall ARS at AAO-HNS meeting.

We thank you again for your help in this worthy endeavor.

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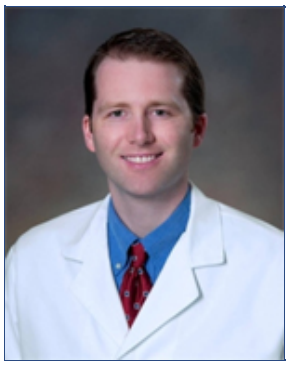
Back to top

AWARDS COMMITTEE REPORT



David Poetker, MD, MA

2014 has been another great year for the ARS Awards Committee. It is an honor and pleasure to have the opportunity to read and review the best research manuscripts of the very talented ARS members.

The **2014 Basic Science Research Awards** were won by:
Vijay Ramakrishnan, MD for his submission to COSM, entitled *Sinus microbiota in chronic rhinosinusitis*.

Emily Cope, PhD for her manuscript entitled *Sinus instillation of Lactobacillus sakei moderates Pseudomonas aeruginosa infection and increases airway microbiome resilience in a murine model*, presented at the ARS at AAO-HNS in Orlando last month.

The **2014 Clinical Manuscript Awards** went to:
Evan Walgama, MD for his manuscript *Cost-effectiveness analysis of medical therapy versus surgery for chronic rhinosinusitis*, presented at COSM.

Joe Han, MD took the prize at the fall meeting for *A randomized, controlled, blinded study of bioabsorbable steroid-eluding sinus implants for in-office treatment of recurrent sinonasal polyposis*.

Congratulations to the award winners and to all of the authors for truly excellent research.

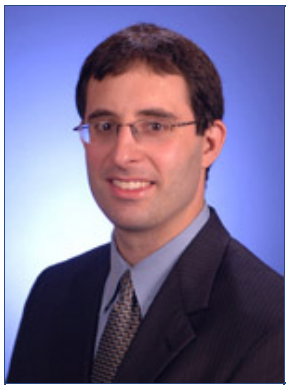
As always, a special thanks to the members of the Awards Committee: Naveen Bhandarkar, Martin Citardi, Mohamed Hegazy, Tom Higgins, Ayesha Khalid, John Lee, Lori Lemonnier, John Osguthorpe, Steve Pletcher, Nathan Sautter, Rod Schlosser, Kristin Sieberling, and Marilene Wang.

Welcome to our newest members: Stella Lee, Jayant Pinto, Eric Wang, and Charles Ebert, as well as the new Chair of the Awards Committee, Marilene Wang.

Anyone interested in being a member of the ARS Awards Committee can submit an application for committee membership.

Back to top

PAC CORNER: CODING FOR EPISTAXIS



Seth M. Brown, MD, MBA

Epistaxis coding tends to be a confusing area for a number of surgeons. The following summarizes coding for epistaxis in the office and operating room. All the office based epistaxis codes have a zero day global period.

For nasal cautery or packing not requiring endoscopic guidance use the following codes (these are unilateral codes and a 50 modifier can be applied):

30901- control of nasal hemorrhage, anterior, simple
30903- control of nasal hemorrhage, anterior, complex (extensive cautery or packing)

If an endoscope is used for visualization of the bleeding source, but is not needed for control of epistaxis, then 31231 (nasal endoscopy, diagnostic) can be billed. This is usually instead of, not in addition to, the above codes.

If control of epistaxis requires posterior packing or cautery, use the following codes:

30905 – control of nasal hemorrhage, posterior (for the primary procedure)
30906 – control of nasal hemorrhage, posterior (subsequent)

If a nasal endoscope is needed to control the bleeding then use the following code:

31238 – nasal endoscopy with control of nasal hemorrhage (this is a unilateral code)

For open ligation of arteries use the following codes (both are 90 day global periods):

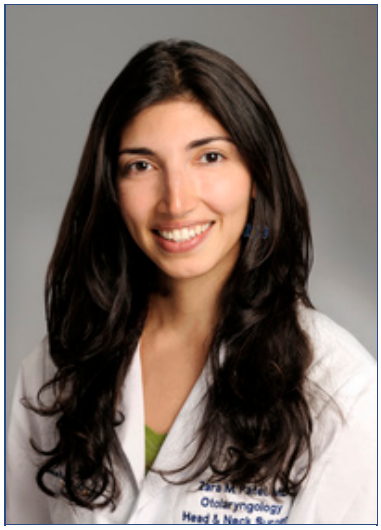
30915 – ligation arteries, ethmoidal
30920 – ligation arteries, internal maxillary artery, transantral

If an endoscopic sphenopalatine artery ligation is performed, an unlisted code, 31299, should be used, as no code exists to specifically describe the work. When billing, use a comparison code, such as the open ligation code, 30920. This comparison of work makes the most sense.

As always, please review codes with your professional coders when unclear of the proper code and contact the ARS if assistance is needed.

Back to top

EDUCATION COMMITTEE UPDATE



Zara M. Patel, MD

Over the last two years, Rick Chandra has led the education committee to great accomplishments, including continued oversight of the educational and informational content via the American Rhinologic Society website, the webinar series, the annual Fellow's Course, and the Summer Sinus Symposium.

The website includes over 40 pages of educational content regarding anatomy and physiology of the nose and paranasal sinuses, common and interesting disorders, and various therapeutic measures. Content has been provided by dozens of contributors, to whom we are appreciative. Please visit the patient care website, and consider linking your practice's website here. Kevin Welch has been instrumental in technological support for this endeavor, for which we thank him. In the coming year, we will aim to revisit and revitalize all this content to ensure it remains as up to date as possible. We are always open to ideas for new content, both from physicians and our patients.

Chris Church has worked tirelessly to ensure the webinars continue to broadcast interesting and relevant material. Due to the differing time zones our wide audience resides within, he and the IT committee have succeeded in archiving these as "podcasts"

on the ARS website (login required), which can be accessed whenever the viewer desires.

Once again, with the dedicated help of Jeff Suh and Joe Han, the Fellow's Course, supported by Karl Storz, was strongly reviewed by attendees. The program continues to evolve, in order to provide valuable experience to those entering our ranks. Furthermore, the course has been an excellent opportunity to build camaraderie and collegiality amongst each incoming "class" of rhinologists.

Many thanks to Rick Chandra, Kevin Welch and Jim Palmer for the resounding success of the 3rd Summer Sinus Symposium this year, with 490 attendees, many of whom have deemed it the best sinus course in the world. We're grateful to the 100+ faculty, volunteers and honored guests, all of who have selflessly given time away from their practices and families. Rick, Kevin and Jim are continually seeking ways to make this course more interesting and attractive to society members, trainees, allied health professionals and, most importantly, to the otolaryngology community at large.

I thank Rick Chandra and all the outgoing committee members for their extraordinary service in this capacity, and hope that as the incoming Education Chair, I, along with the other incoming committee members, can continue the exceptional tradition of expanding this committee's reach and vision for our members and our patients over the next two years.

Back to top

CASE OF THE QUARTER: SINONASAL MYOEPITHELIOMA

Zachary Bear, MD & Jastin Antisdel, MD, FACS

A 77 year-old female presented to clinic with long-standing sinonasal complaints including right-sided nasal fullness and pain in her right maxillary dentition when eating. Over the past two months she had noted increasing right-sided nasal obstruction. Her primary care physician had ordered an MRI and referred her to an outside otolaryngologist who then sent her for tertiary management of a large right sinonasal mass. Exam revealed tenderness to palpation in the right V2 distribution with anterior rhinoscopy showing a large mucosalized mass filling the right nasal cavity with associated leftward septal deviation. CT and MRI revealed a large mass filling the right maxillary sinus and nasal cavity extending into the right masticator space with destruction of part of the hard palate and displacement of the orbital floor (Figures 1 and 2). Biopsies from clinic were consistent with a myoepithelioma.

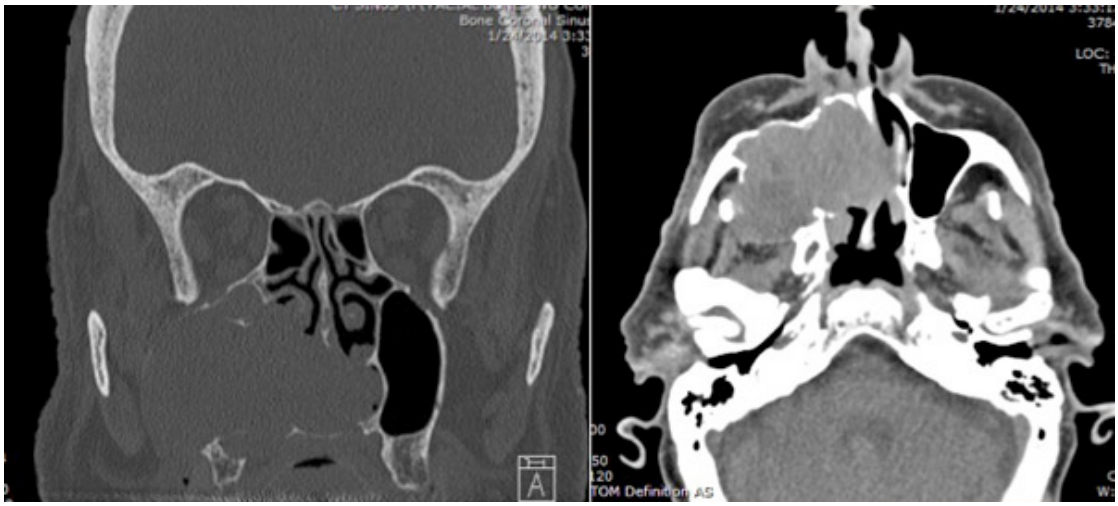


Figure 1 (left): Preoperative coronal CT bone window showing involvement of right hard palate and pterygomaxillary fossa
Figure 2 (right): Axial CT soft tissue window

Surgical excision was accomplished with a right Caldwell-Luc, endoscopic medial maxillectomy, and a septectomy approach using a microdebrider and coblator. The mass appeared to be pedicled at the superior aspect of the right lateral nasal wall near the uncinate. Intraoperatively the mass was noted to be eroding through the septum, lateral maxillary sinus wall, orbital floor and hard palate. Complete gross surgical excision was accomplished. Final pathology was again consistent with a myoepithelioma.

The patient underwent serial debridements in the office following surgery. Her 6-month follow up endoscopy and MRI showed no evidence of persistent or recurrent disease (Figures 3 and 4). The patient had no changes in vision or evidence of an oro-antral fistula.

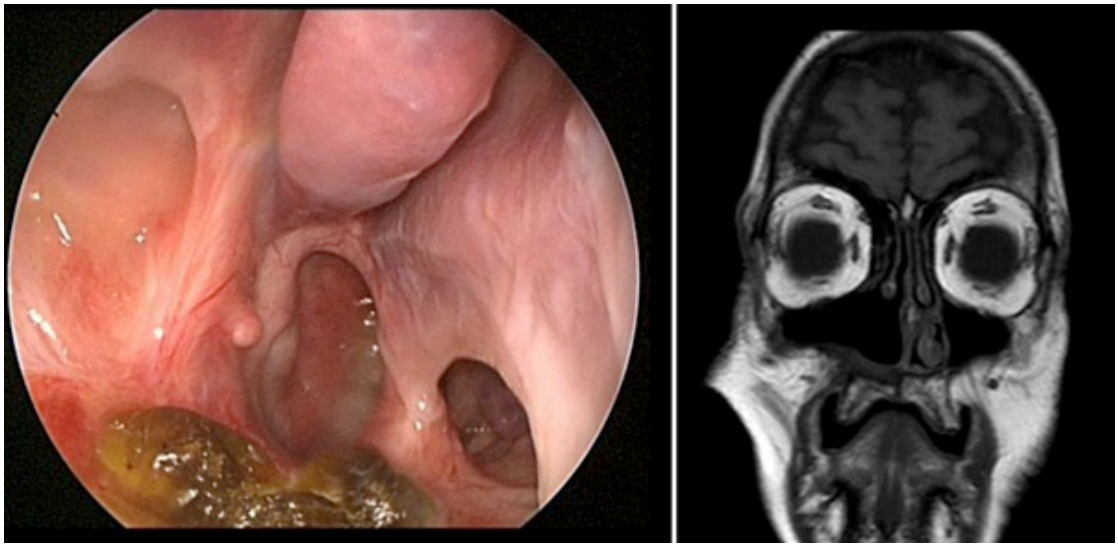


Figure 3 (left): Six-month postoperative endoscopic exam of right nasal cavity. Wide maxillary antrostomy and septal defect noted. No evidence of residual tumor.
Figure 4 (right): Six-month postoperative T1 MRI. No evidence of residual tumor.

A myoepithelial cell is a contractile cell associated with tissues with secretory function. A myoepithelioma is a well-circumscribed benign tumor originating from myoepithelial cells. It accounts for 2.2%-5.7% of benign salivary tumors.[1] A benign myoepithelioma may also arise from the seromucinous glands of the nasal cavity or larynx with reports of laryngeal and palatal origins.[2,3] The first report of a sinonasal myoepithelioma in the literature was in 1993 in a 38 year old woman presenting with otalgia and facial pain. She was found to have a large mass in the right maxillary sinus and pterygopalatine fossa.[4] There are case reports of endoscopic resection of a septal based myoepithelioma and recurrent sinonasal myoepithelioma requiring multiple procedures to debulk the mass.[5,6]

In the head and neck, myoepithelioma most commonly arises in the parotid gland, and is treated like other benign salivary tumors.[7] CT scans of parotid myoepitheliomas typically show a well circumscribed, enhancing lesion with smooth or lobulated margins.[8] The treatment recommendation for sinonasal myoepithelioma is complete surgical excision after pathologic confirmation.[4,5,6]

Myoepithelial carcinoma is a malignant counterpart to benign myoepithelioma. At least half are thought to arise from preexisting benign myoepitheliomas or pleomorphic adenomas.[1] Again, myoepithelial carcinomas are found most commonly in the parotid and minor salivary glands, but there are reports of sinonasal involvement.[1] Unlike the benign myoepithelioma, the myoepithelial carcinoma shows infiltration into adjacent tissue and the ability to metastasize.

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Back to top

FELLOWSHIP COMMITTEE REPORT

Todd Kingdom, MD

June 2014 marked the 9th consecutive and successful rhinology match process in collaboration with the San Francisco Match Program. We have seen tremendous growth in both international and US medical graduates since the inception of the program. Sixteen programs offered 16 training positions during the inaugural match in 2006. The 2014 cycle saw 24 programs offer 26 positions. Interest remained very strong with 55 applicants registering for the match – 33 from US medical schools and 22 international medical graduates (IMG). Ultimately, 42 applicants submitted ranks lists (29 US / 13 IMG) and entered the match process. Twenty-three positions were filled with 3 programs initially not matching an applicant. All of these programs filled their positions after the match through the “scramble” process. 65% of applicants matched to one of their top 3 choices while 79% of programs matched one of their top 3 selections.

In 2014, we once again saw great interest from international graduates in our rhinology fellowship match process and training programs. The numbers have remained stable now for the past several years with approximately 20-22 applicants registering for the match each year and 12-14 ultimately submitting rank lists. Three IMGs matched this past June. However, they were all from Canadian medical schools. This is the first time in many years we did not have at least one IMG outside of North America match. Under the direction of Roy Casiano, a working group of the Fellowship Committee is exploring initiatives to better serve this unmatched IMG group searching for training opportunities in the US. We see this as a tremendous opportunity and will continue to provide better solutions going forward.

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Back to top

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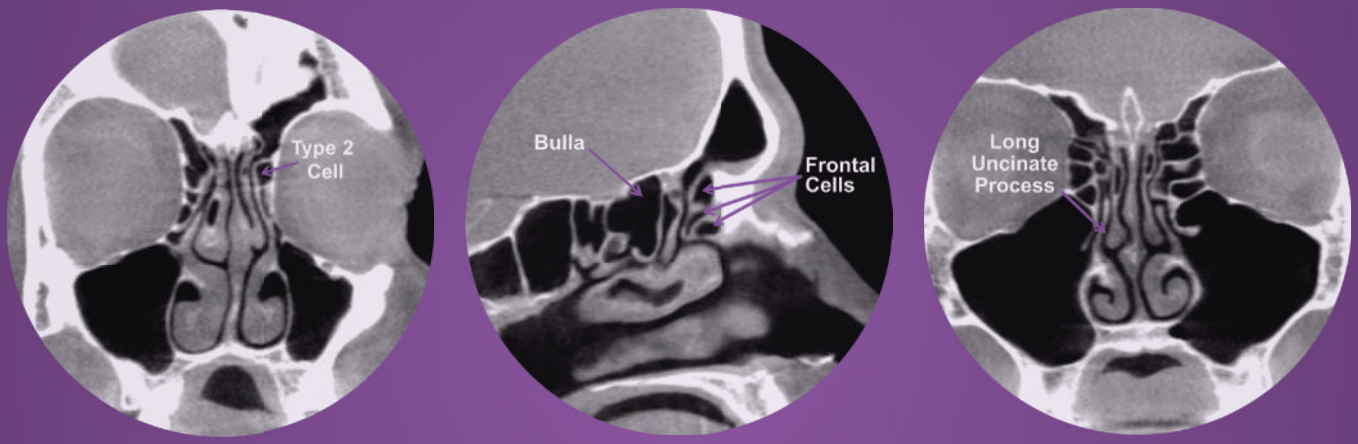
nose news

Back



FLEXIBILITY MATTERS

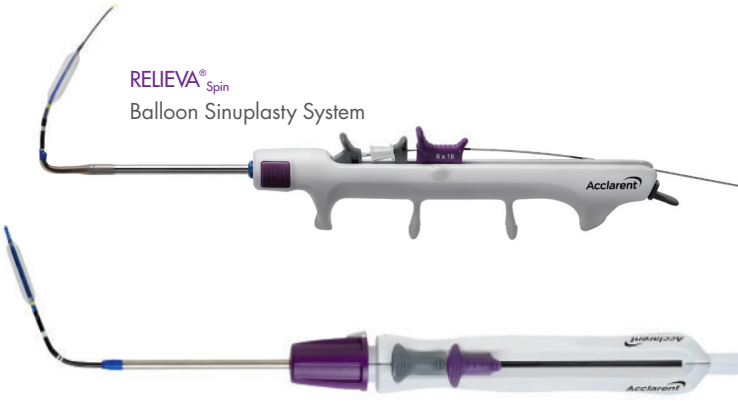
Unsurpassed reach and flexibility.

Challenges in CRS management include highly complex frontal and variable maxillary sinus anatomy.[1,2] RELIEVA® dilation systems provide reliable performance with confident sinus access and safe dilation of the target ostium.[3–5]

Discover the advantages of Acclarent flexible, over-the-wire technology.

- > **Flexible design** to traverse tight or tortuous anatomy
- > **Pinpoint confirmation** with RELIEVA LUMA SENTRY®
- > **Balloon extension** beyond the reach of rigid instruments
- > **Atraumatic design** to preserve anatomy and minimize tissue trauma

View why flexibility matters at:
www.acclarent.com/WhyFlexMatters



RELIEVA® Spin
Balloon Sinuplasty System

RELIEVA SCOUT™
Sinus Dilation System

1. Dearking AC, Pallanch JF. Mapping the frontal sinus ostia using virtual endoscopy. *Laryngoscope.* 2012;122(10):2143-2147.
2. Sikand A. Computed tomography-based exploration of infundibular anatomy for maxillary sinus balloon dilation. *Ann Otol Rhinol Laryngol.* 2011;120(10):656-662.
3. Levine HL, Sertich AP, Hoisington DR, Weiss RL, Pritikin J. Multicenter registry of balloon catheter sinusotomy outcomes for 1,036 patients. *Ann Otol Rhinol Laryngol.* 2008;117(4):263-270.
4. Karanfilov B, Silvers S, Pasha R, Sikand A, Shikani A, Sillers M; ORIOS2 Study Investigators. Office-based balloon sinus dilation: a prospective, multicenter study of 203 patients. *Int Forum Allergy Rhinol.* 2013;3(5):404-411.
5. Weiss R, Church CA, Kuhn FA, Levine HL, Sillers MJ, Vaughan WC. Long-term outcome analysis of balloon catheter sinusotomy: two-year follow-up. *Otolaryngol Head Neck Surg.* 2008;139(3)(suppl 1):S38-S46.

Important Safety Information
Acclarent devices are intended for use by or under the direction of a physician who is trained in the use of Balloon Sinuplasty Technology. Prior to use, it is important to read the Instructions for Use and to understand the contraindications, warnings, and precautions associated with these devices, as well as all products mentioned in this advertisement.

Indications for Use
The Instructions and Indications for Use can be found at www.acclarent.com.

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entellus MEDICAL™

One treatment has been proven in a randomized trial to be as effective as functional endoscopic sinus surgery while providing better patient recovery outcomes

= ENTELLUS BALLOON SINUS DILATION

Across 7 Entellus studies with over 450 patients, balloon sinus dilation has been proven an effective, durable and safe treatment option

- Proven as effective as standard of care (FESS) for long term symptom improvement
- Patients who had experienced an average of 5.2 episodes of rhinosinusitis requiring medication per year and had been symptomatic for over 12 years reported on average only a single episode of rhinosinusitis in the year following treatment with balloon sinus dilation

In-office balloon sinus dilation offers patients a more comfortable and convenient treatment option

- 2.5X more sinusitis patients would opt for a less invasive office procedure versus traditional sinus surgery

Entellus enables physicians to confidently access and treat all sinuses

EASY START

- Entellus has a high success rate of sinus dilation – over 96% across 5 studies
- Only Entellus' seeker-based design empowers physicians with the direct control, tactile feel and visualization to access even the toughest anatomy
- Only Entellus offers 5 methods to confirm device placement

For more information, contact Entellus at
866-620-7615, or visit www.EntellusMedical.com

XprESS Indications for Use: To access and treat the frontal recesses, sphenoid sinus ostia and maxillary ostia/ethmoid infundibula in adults using a trans-nasal approach. The bony sinus outflow tracts are remodeled by balloon displacement of adjacent bone and paranasal sinus structures.
CAUTION: Federal (USA) law restricts these devices to sale by or on the order of a physician.
Published references and/or data on file at Entellus Medical.

1738-274 rA 05/2014

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