american rhinologic society
nose news

NOSE NEWS FEBRUARY 2015

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COSM: A LOOK AHEAD

Peter Hwang, MD
President Elect and Program Chair

Registration is now open for the ARS at COSM in Boston! Please plan to join us for a stellar program that will encompass the full range of contemporary rhinology, featuring the best clinical and basic research, as well as a variety of expert panels, including:

- Great Debate: Maximal medical therapy-- Does the ARS membership have it wrong?
- Great Debate: Stents and balloons-- worth the cost?
- State of the Art Update on Cystic Fibrosis
- State of the Art Update on Endoscopic Orbital Surgery
- Expert Panel: I just had a complication… now what?

The meeting will be held April 23-24, 2015 at the Hynes Convention Center, Boston, Massachusetts. Early registration is available through March 23. Hotel room blocks have been secured at the Sheraton Boston and the Boston Marriott Copley Place and can be reserved through the COSM website. Register and reserve your accommodations soon.

See you in Boston!

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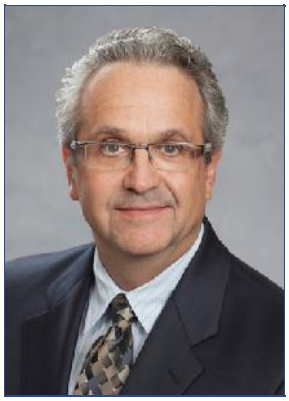
PRESIDENT'S REPORT



Roy Casiano, MD, FACS

I'd like to thank all our members for their continued support and feedback. We are looking forward to another banner year in membership enrollment, active participation in ARS committees, and a continued increase in attendance at our 3 annual educational venues (ARS at COSM, Summer Sinus Symposium, and ARS at the AAO-HNS). Whether you are a community otolaryngologist who does some rhinology, or an academic rhinologist at a major medical center, the Society wants to be sensitive to your needs, and will continue to look for innovative ways to promote its mission of advocacy, teaching, and cutting edge research, in order to provide you with the most effective tools to manage your patients.

In the past few years we have come a long way to accomplish this in a cost-effective way to our membership. New innovative teaching methods, such as utilizing online video-streaming webcasts, interactive panel discussions looking at current controversial issues, as well as hands-on cadaver dissection workshops at our major meetings, are all currently available to our members. New this year, we are offering free registration to our very popular Summer Sinus Symposium Meeting for all ARS members, as one of the many benefits of being a member.

We are actively collaborating with sister societies on a number of educational initiatives as well. We have embarked on a number of international outreach programs, in order to reach many less fortunate otolaryngologists who do not have the means to travel to our meetings, but want access to the latest in rhinologic healthcare for their patients. In conjunction with the AAO-HNS, we have developed an International Visiting Scholars program for rhinology. This program would allow young otolaryngologists with an interest in rhinology and future opinion leaders in their country, to visit us at our fall ARS and AAO-HNS meeting, followed by 3 weeks observing in a rhinology program of their choice. In collaboration with the Panamerican Association of Otolaryngology, we are also looking into providing the first live international webcast of our fall ARS meeting to our international colleagues. Going forward, the ARS will continue to provide valuable leadership and direction, and collaborate with our sister societies, to work together on issues that affect our mutual organizations and members.

Issues concerning CPT coding, insurance denials of effective FDA-approved products, and other patient or physician advocacy concerns continue to take center stage, and will continue to do so in the foreseeable future. However, we are in a good position to confront these challenges together. Our Society leadership will continue to make every effort to engage our major carriers, corporate partners, and sister societies to work together in the best interest of our patients. We will continue to provide you with the latest evidence-based recommendations through cutting-edge research, with a goal of reducing human suffering and improving clinical outcomes. Of course, a lot of this research would not be possible without the support of members like you, who donate to our “Friends in Research” fund, as well as our corporate partners, who have provided unrestricted research grants for young investigators. If you haven't donated to our "Friends in Research" fund, I encourage you to do so online. Every little bit helps!

As you can see, there are a lot of exciting new things happening at the ARS! Please visit the ARS website to learn more about our many initiatives and programs currently available. I hope to see you at our next ARS meeting in Boston, April 23-24, 2015.

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SUMMER SINUS SYMPOSIUM 2015…RIGHT AROUND THE CORNER!

Kevin Welch, MD
Rick Chandra, MD

On behalf of the program committee, we're thrilled to once again invite you to the Summer Sinus Symposium, which will take place on July 16-18 in Chicago, IL at the Westin Michigan Avenue. This is the 4th Annual Symposium, and if history repeats itself, this will be the **best sinus course in the world**. We'll pack the Westin Michigan Avenue for 2 ½ days to tune in to the experts who will discuss all aspects of rhinology and sinus surgery.

Plan to arrive early on Thursday the 16th (or on Wednesday night). Thursday afternoon will be filled with satellite symposia where you'll get to explore new technologies with our corporate sponsors. Spend Friday the 17th with us in the main ballroom as we listen to ARS leaders guide panel discussions about frontal sinus surgery, balloon dilation, "recalcitrant sinusitis, and rhinologic emergencies. Gather pearls of wisdom and interact with Drs. Brent Senior and Alexander Chiu as they perform expert cadaver dissections. Send your text messages live to the panelists and engage in debates over the management of sinusitis. Round out your experience on Saturday the 18th as we break into three groups to learn about the management of allergic diseases, septoplasty and turbinate reduction, functional and cosmetic rhinoplasty, extending sinus surgery beyond the sinuses, performing office based procedures, and opportunities abroad where you can offer your skills as a sinus surgeon. Participants will be able to freely float back and forth among the breakout rooms to focus upon areas of particular interest.

Join us Friday night on the 95th floor of the John Hancock Tower for a cocktail reception while taking in breathtaking views of the city, Lake Michigan and the west side of Chicago. Also, rise early for daily breakfast symposia where you can learn more about surgical techniques, and listen to experts discuss and demonstrate the latest technologies.

As members, you form the backbone of our society and help make the Summer Sinus Symposium the best it can be, and as a thanks to you, registration for the Summer Sinus Symposium is **complementary** as long as your ARS membership dues are up to date.

Join us! It's a meeting that isn't to be missed. Chicago is also a terrific summer destination for couples and families!

Register Now!

For more information, please visit the Summer Sinus Symposium Website. To become a member of the ARS, please fill out an application.

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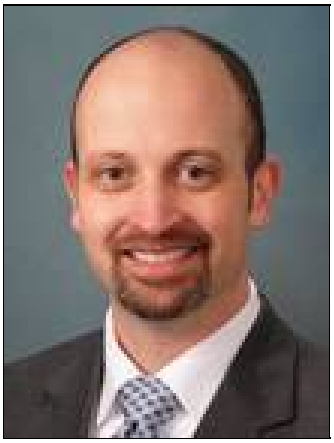
WHY I AM A MEMBER OF THE ARS

Craig Fichandler, MD



When talking to others about considering membership in the ARS, most interested individuals ask, "Well, why did you join?" There are many answers to this question. Some answers are obvious, and others more personal. Firstly, I feel an obligation to my colleagues and the field of rhinology to maintain an affiliation with its dedicated organization. After fellowship, there was a calling to continue to share and aggregate ideas with other specialists. Membership in the ARS allows me to focus my attention on rhinology and sustain the concept of "lifelong learning" without difficulty.

The best ways to stay up to date in a field are to read recent peer reviewed literature and to communicate with others. As a member of the ARS, one of the greatest benefits is receiving the monthly issue of the International Forum of Allergy & Rhinology (IFAR). Within this journal, readers get the most innovative and pertinent data for current rhinologic practice. However, this information is not just for rhinologists. Most, if not all otolaryngologists treat patients with sinonasal pathology, making it important to stay up to date in this constantly evolving field. I have never read an issue that does not have applicable information to any otolaryngology practice.

Membership in the ARS now offers a new benefit: **free registration to the Summer Sinus Symposium**. This meeting offers practical, clinically applicable information to all those with an interest in rhinology. Furthermore, the Summer Sinus Symposium allows a forum for open communication between those involved in rhinology, leading to personal and professional growth of individual physicians and the discipline in general. With registration now included in my ARS membership fee, I continue to see tangible benefits from my membership dollars.

The ARS website also offers many benefits exclusive to members, including our successful webinar series. These webinars offer lectures on a variety of rhinologic topics from leading experts in the field. Residents and attendings will find these lectures both informative and applicable to practice, and they are available exclusively to members.

After reflecting on everything the ARS has to offer, most individuals realize that the advantages and privilege of membership are plentiful. Whether it be the collegial interaction, the outstanding journal, the free summer sinus symposium registration, or the educational benefits available on the website, the ARS remains a positive driving force both in the field of rhinology and my practice. I encourage members to not only utilize these resources, but to spread the word on otolaryngology's best kept secret.

If you are interested in membership in the ARS, please visit the membership pages.

Remember, resident membership is free, so be sure to sign up today!

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MEMBERSHIP COMMITTEE UPDATE

Chris Melroy, MD

The ARS continues to grow through us, the members, and is pleased to announce a new incentive to ARS membership: **SUMMER SINUS SYMPOSIUM REGISTRATION IS NOW FREE FOR PAID MEMBERS OF THE ARS!**

The society maintains very reasonable membership rates. 2015 dues were due on December 31, 2014, and we appreciate your attention to this. If you have not renewed your membership, please do so online- there is a link to renew on the home page that takes less than a minute to complete. This will insure that you don't have any interruption in your IFAR journal delivery and other membership benefits. If you are interested in joining the ARS for the first time, please visit our membership pages. Residents are especially encouraged to join, as membership is free, allowing an opportunity to explore all the ARS offers its members.

The American Rhinologic Society is only as strong as its membership; it's only as strong as we are. Regardless of the specifics of our day-to-day jobs, we are members of this network of professionals all over the world with common interests- to serve, represent, and advance the scientific and ethical practice of Rhinology. This is the mission of the ARS. Thanks for being a part of this group, and please help us become stronger. Thanks for renewing your membership and please encourage your colleagues to join.

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RHINOLOGY PERSPECTIVES: PEDIATRIC RHINOSINUSITIS GUIDELINES

Sanjay R. Parikh, MD, FACS

Pediatric rhinosinusitis has a high epidemiological prevalence – a child will have 6 to 8 upper respiratory tract infections in any given year with approximately 5-10% of these being complicated by acute bacterial sinusitis.[1,2]

A review of the recent scientific literature for pediatric rhinosinusitis reveals a handful of prospective studies or randomized control trials which limits the ability to develop definitive treatment algorithms. For example, a 2014 Cochrane Review by Shaikh & Wald of 662 studies demonstrated no evidence to support the use of decongestants, antihistamines, or nasal irrigation for pediatric acute rhinosinusitis.[3] These studies plus observational and retrospective studies still influence our clinical judgment. Several medical societies have gathered experts to digest this literature to develop reasonable guidelines to assist practitioners in their clinical decision-making. Here are the most recent guidelines with specific pediatric content presented in table form for comparison and contrast:

- EPOS 2012 - European position paper on rhinosinusitis and nasal polyps 2012. A summary for otorhinolaryngologists.[4]
- AAP 2013 - American Academy of Pediatrics: Clinical practice guideline for the diagnosis and management of acute bacterial sinusitis in children aged 1 to 18 years.[5]
- AAOHNS 2014 – Clinical consensus statement: pediatric chronic rhinosinusitis.[6]

Pediatric Acute Bacterial Rhinosinusitis Guidelines

	EPOS 2012	AAP 2013
Definition	**Symptoms:** 2 symptoms (1 must be nasal obstruction or discolored discharge +/- frontal pain, headache, cough) **Duration:** >10 days or increasing symptoms >5days	**Symptoms:** Nasal discharge, daytime cough, or fever **Duration:** Nasal discharge or cough >10 days; Severe onset (fever and discharge) >3 days
Investigations	**Imaging:** Not recommended **Laboratory:** Not recommended	**Imaging:** Not recommended **Laboratory:** Not recommended
Treatment	**Medication:** Topical steroids + consideration for antibiotics **Duration:** 7-14 days	**Medication:** Amoxicillin with or without clavulanate **Duration:** 10 days

Pediatric Chronic Rhinosinusitis Guidelines

	EPOS 2012	AAOHNS 2014
Definition	**Symptoms:** At least 2 symptoms (1 must be nasal obstruction or nasal discharge +/- facial pain/pressure, cough) **Duration:** >12 weeks	**Symptoms:** At least 2 symptoms (purulent discharge, obstruction, facial pressure/pain, cough) and corresponding endoscopic and/or CT findings **Duration:** >90 days
Investigations	**Imaging:** None unless surgery being considered **Laboratory:** Culture	**Imaging:** None unless surgery being considered **Laboratory:** Allergy evaluation for older children
Treatment	**Medication:** Antibiotics **Antibiotic Duration:** 4 weeks **Surgery:** Consider adenoidectomy and sinus irrigation prior to FESS	**Medications:** Daily topical nasal steroid spray, daily topical nasal saline irrigation, antibiotics **Antibiotic Duration:** 20 days **Surgery:** Initial adenoidectomy for <12 years age. Consider ESS when medical therapy, adenoidectomy, or both have failed

In summary, several decent quality studies have resulted in expert guidelines for the treatment of pediatric rhinosinusitis, but there is great opportunity for the scientific development of definitive treatment algorithms.

References:

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PAC CORNER: USE OF THE 22-MODIFIER

Seth M. Brown, MD, MBA

Modifiers are used to indicate that a service or procedure has been altered by some specific circumstance but has not changed by its definition or code. The 22-modifier is specifically used when the work required is substantially greater than typically required.

This can only be placed on a procedure code and not added onto an E/M service.

A 22 modifier can be used for additional work that can include:

- Increased intensity
- Time
- Technical difficulty
- Severity of the patient's condition
- Physical or mental effort required

When using the 22-modifier, documentation is required that supports the additional work and the reason for its use. This can be accomplished in the operative report, but it is often helpful to include a detailed letter to the payer that describes the rationale for the use of the 22-modifier. In addition to the description that makes the situation unique, the letter should detail the additional payment requested. A standard amount that a payer will allow is usually 20%, though the surgeon can ask for more if appropriate. It is not uncommon that using the 22-modifier will delay payment and require an appeal.

An example of when to use a 22-modifier would be, for example, an extended frontal sinusotomy. The following statement, in the form of a letter, would reflect this. "On April 3rd, I performed an extended frontal sinusotomy on Mrs. Jones. This was a patient referred by an outside Otolaryngologist for tertiary level care requiring revision sinus surgery. The procedure involved extending a standard frontal sinus opening by removing the anterior head of the middle turbinate and drilling osteitic bone in order to widely open the sinus and restore its function. This extended approach increased the time and risks of the procedure which include a CSF leak and damage to the orbit.. This extended approach added an extra hour of time to the case. Therefore, I am appending modifier 22 to this procedure code and requesting a 50% increase in payment."

As always, please consult an AMA coding book or your professional coder for assistance.

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ANNOUNCEMENTS

FRIENDS IN RESEARCH CAMPAIGN

We want to express our sincere thanks for the generous donations to the 2014 ARS Friends in Research Campaign.

We again launch our quest to raise money for research with the 2015 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 & 2015 will be invited to a special reception with ARS leadership at the Spring ARS at COSM Meeting Friday April 24, 2015 from 6:30 pm to 8:00 pm EST.

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

ARS FRIENDS IN RESEARCH

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Click to donate now and join us in our 2014 year campaign!
Donate!

RHINOLOGIST AND SKULL BASE SURGEON

Loyola University Health System and Loyola University Chicago Stritch School of Medicine seeks a Rhinologist and Skull Base Surgeon to join the Department of Otolaryngology. The ideal candidate should have experience in the treatment of a wide range of sinonasal disorders such as rhinosinusitis, endoscopic sinus surgery and skull base tumors. A medical degree and board certification in specialty are required. This is a full-time faculty position. Salary will be commensurate with experience. The successful candidate will be at the rank of Assistant or Associate Professor.

The Rhinology and Skull Base Surgery program at Loyola is regionally, nationally and internationally recognized as a leader in the field. Based in the western suburbs of Chicago, Loyola University Health System is a quaternary care system with a 61 acre main medical center campus and 22 primary and specialty care facilities in Cook, Will and DuPage counties. The medical center campus is conveniently located in Maywood, 13 miles west of the Chicago Loop and 8 miles east of Oak Brook, Ill. The heart of the medical center campus, Loyola University Hospital, is a 570 licensed bed facility currently undergoing a significant expansion project. It houses a Level 1 Trauma Center, a Burn Center and the Ronald McDonald® Children's Hospital of Loyola University Medical Center. Also on campus are the Cardinal Bernardin Cancer Center, Loyola Outpatient Center, Center for Heart & Vascular Medicine and Loyola Oral Health Center as well as the LUC Stritch School of Medicine, the LUC Niehoff School of Nursing and the Loyola Center for Health & Fitness.

For decades, Loyola University Medical Center has had a close partnership with Edward Hines, Jr. VA Hospital. Loyola's campus in Maywood, IL lies immediately east of Hines' campus. Most faculty members of Loyola's Stritch School of Medicine have joint appointments at Hines, and Loyola students and resident physicians rotate through Hines as part of their training. Researchers from Loyola and Hines have collaborated closely on many federally funded studies

Interested candidates should address cover letter and CV to Dr. James Stankiewicz and email to Michelle Pencyla, Physician Recruitment Office, at mpencyla@lumc.edu as well as apply online at www.careers.luc.edu.

James Stankiewicz, MD
Professor and Chairman, Otolaryngology
Loyola University Medical Center
2160 S. First Avenue
Maywood, IL 60153

Loyola is an equal opportunity and affirmative action employer/educator with a strong commitment to diversifying its faculty.

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CASE OF THE QUARTER

Joshua Weiss, MD, Christopher Carter, MD and Jeb Justice, MD

A 74 year-old nonsmoking Caucasian female with a past medical history including type II diabetes mellitus, hypertension, and congestive heart failure presented to her primary physician with a three week history of right cheek numbness and occipital headaches. MRI showed a T2-hypointense and T1-isointense homogeneously enhancing right posterior-lateral maxillary sinus mass involving the infraorbital nerve with questionable involvement of the orbital floor (Figure 1). She was then referred to Otolaryngology clinic. She denied vision changes, otologic symptoms, cervical or systemic lymphadenopathy, anosmia, nasal obstruction, or constitutional symptoms. On exam, she had decreased sensation over the right V2 distribution and normal extraocular motion. In-office nasal endoscopy revealed purulence draining from the right middle meatus but was otherwise normal. Subsequent maxillofacial CT scan (Figure 2) confirmed the MRI's finding of a mass arising from the posterior wall of the right maxillary sinus, both within the sinus and the posterior periantral fat extending to the pterygopalatine fossa. There was also bone involvement including the orbital floor and the infraorbital canal.

Figure 1: Axial T2 weighted MRI showing hypo intense mass along postero-lateral right maxillary sinus

Figure 2: Coronal CT scan showing right maxillary sinus mucosal thickening, reactive bone changes along the infra-orbital canal, and incidental right molar tooth periapical cyst.

She was taken to the operating room where a right maxillary antrostomy and anterior ethmoidectomy were performed to provide access to the large mass, which filled nearly two-thirds of the maxillary sinus. This was adherent to the posterior and lateral walls as well as the roof of the sinus along the infra-orbital nerve canal (Figure 3). Large portions of the irregular polypoid mass were sent for frozen section, fresh for lymphoma evaluation, and for permanent histopathology. Frozen section was unable to determine the nature of the mass and was initially read as a “polypoid lesion.” The mass was dissected from the lateral wall, the posterior wall, and from the floor of the maxillary sinus. The majority of the mass was removed, purposely leaving a small amount along the infraorbital nerve in an effort to avoid paresthesia or neuralgia prior to a known diagnosis.

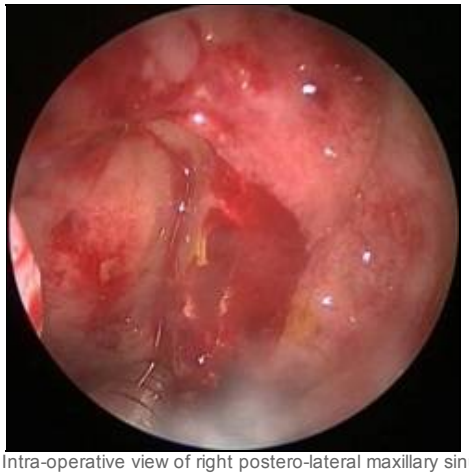

Figure 3: Intra-operative view of right postero-lateral maxillary sinus mass.

The initial impression at the time of frozen section was a lymphoplasmacytic infiltrate without obvious malignancy, and flow cytometric analysis was negative for evidence of a T- or B-cell non-Hodgkin lymphoma. However, the final H&E sections showed submucosal fibrosis with lymphoplasmacytic inflammation, increased eosinophils, and occasional groups of large, multinucleated, malignant lymphoid cells with prominent nucleoli compatible with Reed-Sternberg cells. Immunohistochemistry confirmed strong, membranous immunoreactivity for CD30 in the Reed-Sternberg cells with immunoreactivity for PAX5, variable immunoreactivity for CD15 and CD20, and minimal immunoreactivity for CD45 (Figure 4). The findings were consistent with mucosal involvement by classical Hodgkin lymphoma, nodular sclerosing subtype.

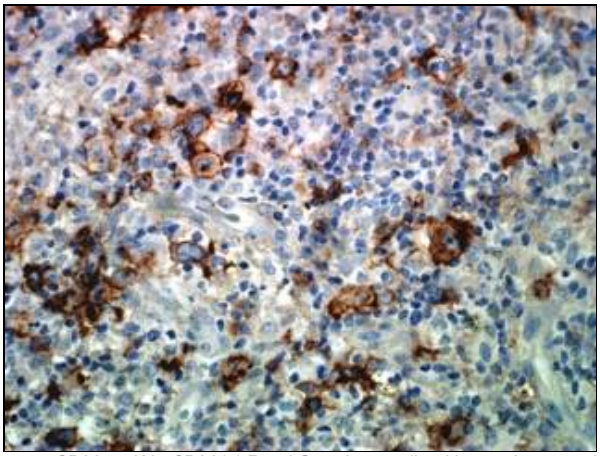

Figure 4: CD30 - 40X - CD30(+) Reed-Sternberg cells with prominent nucleoli

PET/CT showed no evidence of distant disease or other sites of involvement. She is now undergoing chemotherapy and radiation as per the consensus of the multidisciplinary head and neck tumor board.

Hodgkin Lymphoma of the sinuses:
The majority of head and neck lymphomas occur in the cervical lymph nodes and less frequently in extranodal sites, the most commonly in the tonsillar tissue of Waldeyer's ring[1]. Sinonasal lymphomas represent only 1.5% of all lymphomas, with Hodgkin lymphoma occurring significantly less frequently than non-Hodgkin types, which account for 10 and 90 percent, respectively. Two recent institutional reviews with case series of sinonasal lymphomas reviewed 17 cases over a 22 year period and 23 cases over 38 years, none of which were Hodgkin lymphoma, emphasizing the rare nature of this disease in the sinuses.[2,3] Currently, less than five prior case reports of Hodgkin Lymphoma of the paranasal sinuses have been published in the literature.[1,4,5] All of these patients underwent similar workups with operative biopsies or resections followed by chemoradiation. A review for the treatment for sinonasal lymphomas showed good initial control with radiation alone, yet a trend for failures with distant recurrence necessitates systemic treatment with chemotherapy.[2] Overall survival is strongly correlated with disease stage.

Of paramount importance in this case was the specific testing for lymphoma, which was planned pre-operatively based on the imaging characteristics of the patient's lesion. Routine frozen and initial flow cytometry were insufficient for accurate diagnosis. Only after combining these studies with final pathology and immunohistochemistry was the diagnosis confirmed.

In conclusion, although rare, practitioners must consider the diagnosis of lymphoproliferative diseases for unusual, malignant appearing sinonasal masses. Proper studies, guided by a high index of suspicion, including sending fresh tissue for lymphoma evaluation and flow cytometry in addition to routine histopathology and immunohistochemistry give the best change to obtain a proper diagnosis.

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TEDX TALK: WHY WE CAN'T FIX OUR HEALTH SYSTEM

Ayesha Khalid, MD, MBA

Albert Einstein once stated, “We cannot solve problems by using the same level of thinking we used when we created them.” How many of us have had a busy clinic day, juggling complex patients while trying to provide a coordinated patient experience? In my recent **TedX talk**, I explore why we are having difficulties with fixing the current healthcare system. Through my patient Charlie’s eyes, I propose we need a paradigm shift. Systems thinking is a discipline that allows reframing the healthcare conversation. We are systematic when we synthesize diagnostic information to come up with a diagnosis, yet care delivery remains non-systematic. Systems thinking has reframed the conversation in several industries as it looks for leverage points: small actions with big impact. In order to shift our paradigm, we need to ask a different set of questions. As a starting point: Why is competition bad and why are we afraid to learn from failure? In medical school and residency, we are trained to excel and compete to get the highest grades, provide the best care, perform the best surgery - then suddenly we are asked to shift approach and work as part of a healthcare team. Competition is healthy as a driver of excellence, yet even in the research arena, incentives to compete overpower incentives to collaborate. Publishing first and securing funding earliest allows us to advance in academia. However, we may be ignoring the synergies other industries have used to scale and grow through using collaboration. For example, could we share process innovations on best practices for peri-operative flow, algorithms to successfully conduct clinical trials on a multi-institutional level, enhance patient compliance with medication regimens? At the American Rhinologic Society, we have started the conversation on processes through evidence and outcomes-focused presentations, but now we must consider if we are maximizing collaborations within the larger Academy and the house of medicine. Centers of excellence with rhinologists, allergists, and pulmonologists, with patient care linked digitally that the patient can interface with, that is the healthcare of the future.

Leaders in our rhinologic community helped catapult the discussion of surgical complications, and kudos to Dr. Stankiewicz for his revered talk on complications. But have we carried that conversation forward to learning how we fail in terms of keeping patients out of the OR for revision surgery or addressing difficult patient scenarios? As an example of boldly accepting that errors occur, for example, the airline industry has a self-reporting system for pilots that involves self-reporting of missteps and errors in order to have all pilots access and gain knowledge on how to avoid such scenarios in the future, as well as to investigate process flaws that keep planes safe. In fact, aviation authorities incentivize voluntary self-reporting by acknowledging that unless an act was willfully wrongful or neglectful, it will be looked at as a way to perform root cause analysis rather than ascribe blame. Imagine collectively improving our surgical paradigm rather than the culture of shame or blame that exists when surgeons are confronted with risk management or litigation. These are all difficult questions but ones we have the responsibility to start asking within our own system.

My talk is not intended to guide how to “fix the healthcare system” -simply to have us ask a different set of questions. In fact, the upcoming Summer Sinus Symposium, a gathering of eminent rhinologists and thought leaders, is a perfect venue to start having some of these discussions about difficult experiences. As you personally attend the Symposium and sit to grab a cup of coffee with a colleague from across the country and share tough clinical experiences, remember that we as doctors do not always have the answers - even though many people expect us to.

As rhinologists, we can build a culture of collaboration in the pursuit of clinical excellence. I personally look forward to seeing you all in Chicago and welcome your feedback on my talk.

IN CLOSING

Take a moment to explore the ARS Website where you'll find useful meeting-related information and much more.

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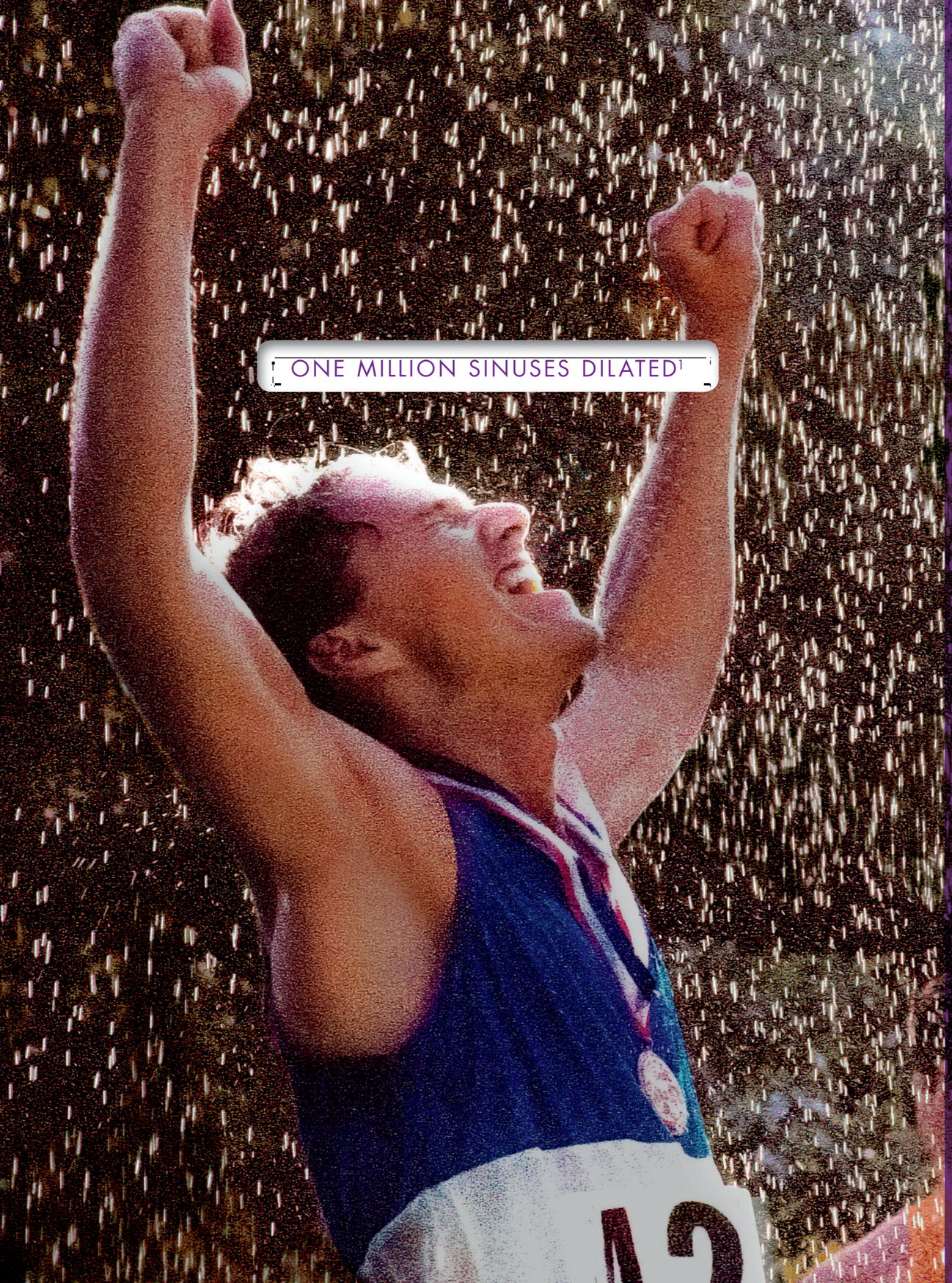

2005

1st Generation Balloon and Guidewire

2006

Additional balloon sizes and Sinus Guide Catheter options

2007

RELIEVA SOLO™ Sinus Balloon Catheter
RELIEVA VIGOR® Sinus Guidewire
RELIEVA VORTEX® Sinus Irrigation Catheter

2008

RELIEVA LUMA® Sinus Illumination System
RELIEVA SIDEKICK® Sinus Guide Catheter
RELIEVA SOLO PRO™ Sinus Balloon Catheter

2009

INSPIRA AIR® Balloon Dilation System
RELIEVA FLEX® Sinus Guide Catheter

2010

RELIEVA LUMA SENTRY®
Sinus Illumination System

2011

ACCLARENT CYCLOPS® Endoscope
RELIEVA ULTIRRA® Sinus Balloon Catheter

2012

RELIEVA® $_{SPIN}$ Balloon Sinuplasty System
RELIEVA VORTEX® 2 Sinus Irrigation Catheter

2013

RELIEVA SCOUT® Sinus Dilation System

2014

RELIEVA® $_{SPIN}$ M110C Sinus Guide Catheter

2015

RELIEVA CIRCA™ Ethmoid Punch

Unrivaled leadership.

Proven, effective, durable relief.[2-4] In Balloon Sinuplasty, experience matters. Acclarent Balloon Sinuplasty is the focus of more studies than any other system. Our system has been used to dilate more than one million sinuses. Acclarent's commitment to provide leading-edge innovations and support surgeons like you has never been stronger.

- A 10-year history of ENT innovation
- The most studied Balloon Sinuplasty System
- First to offer flexible, over-the-wire Balloon Sinuplasty Technology

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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. The INSPIRA AIR® Balloon Dilation System is intended for use by or under the direction of a physician with an understanding of balloon dilatation on the airway tree (trachea and main stem bronchi). This product has associated risks, including serious complications. The ACCLARENT CYCLOPS® Multi-Angle Endoscope is intended for use by or under the direction of a physician with an understanding of endoscopes. For complete information regarding indications for use, contraindications, warnings, precautions, and possible complications, please reference the Instructions for Use.

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

1. Data on file #10. Acclarent. 2. Weiss R, Church CA, Kuhn FA, et al. Long-term outcome analysis of balloon catheter sinusotomy: two-year follow-up. *Otolaryngol Head Neck Surg.* 2008;139:S38-S46. 3. Bolger WE, Brown CL, Church CA, et al. Safety and outcomes of balloon catheter sinusotomy: a multicenter 24-week analysis in 115 patients. *Otolaryngol Head Neck Surg.* 2007;137:10-20. 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.

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- **Engage** the experts: ask them your questions and debate the answers
- **Hear** the experts discuss the pearls and pitfalls of managing sinusitis
- **Watch** seasoned surgeons dissect cadavers while answering your questions
- **Participate** in breakout sessions that are geared towards your practice
- **Become** an ARS Member and enjoy ***FREE SSS registration!***
- **It's not to miss:** It's the ***best sinus course in the world!***

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ARS Membership Benefits:

Membership in the ARS places you in a highly respected professional organization that has a significant and far-reaching impact on the subspecialty of rhinology. The ARS is dedicated to promoting excellence in clinical care, investigation, education, and patient advocacy in the field of rhinology. Membership benefits include:

- A **FREE** subscription to the *International Forum of Allergy & Rhinology,* the official publication of the ARS
- **FREE SSS Registration** plus discounted registration fees for the annual Fall and Spring meetings
- A **FREE** subscription to the ARS newsletter
- **FREE** access to the "Members only" sections of the ARS website
- **FREE** Educational and research benefits
- Advocacy in socioeconomic issues for your rhinology practice
- Professional camaraderie

Membership forms available at:
http://www.american-rhinologic.org/membership_application

American Rhinologic Society

Contact: *Wendi Perez, ARS Executive Administrator*
Tel: 845.988.1631, Fax: 845.986.1527, wendi@amrhso.com
ARS, PO Box 495, Warwick, NY 10990 | **www.american-rhinologic.org/ars_courses**

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REMODEL

Randomized Clinical Trial

Randomized, Controlled Study Reframes the Continuum of Care

REMODEL, sponsored by Entellus Medical, is the first prospective, multi-center, randomized controlled trial with sufficient statistical power to compare ***standalone Balloon Sinus Dilation*** to traditional ***Functional Endoscopic Sinus Surgery (FESS)*** for the treatment of chronic or recurrent sinusitis.

The results affirm data from past studies, and show that while both Balloon Sinus Dilation and FESS deliver comparable, significant symptom improvement and are safe, durable treatment options, choosing to treat with Balloon Dilation can significantly enhance the patient recovery experience. Key findings:

1. EFFECTIVE

Balloon dilation and FESS deliver comparable, significant long-term symptom improvement

	1-YEAR SNOT-20 CHANGE	CLINICALLY MEANINGFUL	P-VALUE	TREATMENT EFFECT SIZE		
				SMALL	MODERATE	LARGE
Balloon Sinus Dilation	-1.64	YES	<0.0001			✔
FESS	-1.65	YES	<0.0001			✔

2. DURABLE

Balloon dilation and FESS deliver comparable durability

= High 96.7% BALLOON DILATION // 98.7% FESS
OSTIAL PATENCY

= Low 2.1% BALLOON DILATION // 2.4% FESS
REVISION RATE

3. BETTER PATIENT EXPERIENCE

✔ LESS PAIN MEDICATION

BALLOON PATIENTS
.9 DAYS
VS
FESS PATIENTS
2.8 DAYS
DURATION OF RX PAIN MEDICATION POST-PROCEDURE

✔ FEWER DEBRIDEMENTS

8% BALLOON PATIENTS
VS
74% FESS PATIENTS
REQUIRED DEBRIDEMENT

✔ FASTER RECOVERY

BALLOON PATIENTS
1.6 DAYS TO RETURN TO NORMAL ACTIVITIES
VS
FESS PATIENTS
4.8 DAYS TO RETURN TO NORMAL ACTIVITIES
70% FASTER

Why Balloon Dilation or FESS? Lasting Change for Sinusitis Sufferers

The impact of sinusitis on patient quality of life is significant. REMODEL collected data on patient experience in the year prior to treatment, and compared it with the experiences of patients the year after treatment with balloon dilation or FESS:

✔ HEALTH

Patients experienced a significant decrease in sinusitis episodes requiring medication

Average Rhinosinusitis Episodes Requiring Medication

	Year Before	Year After
BALLOON DILATION	5.2	1.0
FESS	4.5	1.0

✔ ACTIVITY

Both treatments significantly reduced the negative impact of sinusitis on patient activity levels

Average Reduction of Activity Impairment Due to CRS

	% Reduction
BALLOON DILATION	78%
FESS	79%

✔ PRODUCTIVITY

After treatment, patients missed less work and were more productive while at work

Productivity Impairment Due to CRS

	Average Reduction in Work Missed	Average Reduction in Impairment While Working
BALLOON DILATION	100%	80%
FESS	81%	79%

REMODEL demonstrates interventional treatment of uncomplicated sinusitis, whether with balloon dilation or FESS, can SIGNIFICANTLY ENHANCE a sinusitis sufferer's life.

WHY IS REMODEL SIGNIFICANT?

- Addresses community's desire for an adequately powered prospective randomized controlled trial comparing balloon sinus dilation and FESS
- Affirms place of office balloon dilation in sinusitis continuum of care

WHY DO REMODEL RESULTS MATTER TO YOU?

- You can now treat patients with confidence knowing balloon dilation is as effective as FESS
- You can address dissatisfied medical therapy patients with a lasting treatment option that offers fast recovery and minimal disruption
- Moving treatment of more appropriate patients to the office means a more efficient practice for you
- Balloon dilation improves patient quality of life

Review the complete REMODEL Study and other key clinical literature at www.EntellusMedical.com.

For more information, contact your Entellus Medical Sales Representative.

entellus MEDICAL

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www.EntellusMedical.com
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Bikhazi N, Cutler J, Truitt T, Schwartz M. Standalone balloon dilation versus sinus surgery for chronic rhinosinusitis: A prospective, multicenter, randomized, controlled trial with 1-year follow-up. Am J Rhinol Allergy. DOI: http://dx.doi.org/10.2500/ajra.2014.28.4064. (Published online May 12, 2014)

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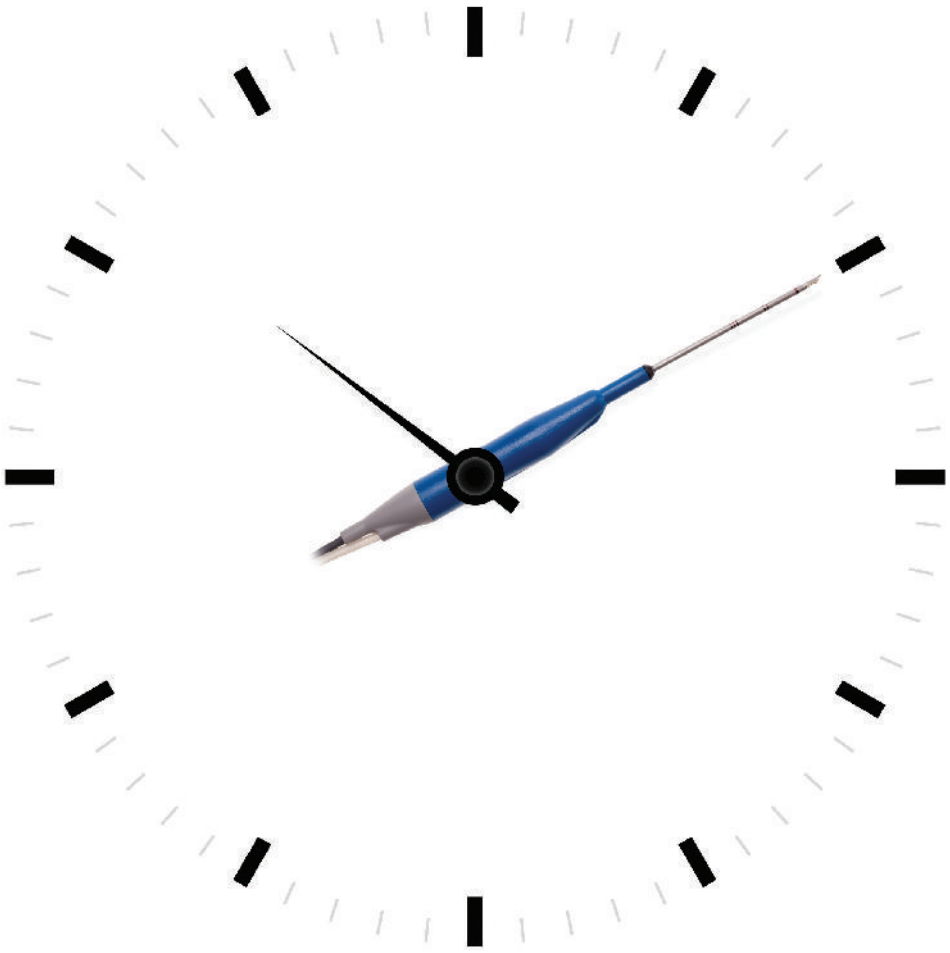

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