Pacific Rim Otolaryngology–Head and Neck Surgery Update

SATURDAY - TUESDAY • PRESIDENTS' DAY WEEKEND
February 17 - 20, 2018

GUEST SPEAKERS
M. Boyd Gillespie, MD
University of Tennessee, Memphis
Michael L. Hinni, MD
Mayo Clinic Arizona
Jeffrey D. Rawnsley, MD
University of California, Los Angeles

COURSE CHAIRS
Andrew H. Murr, MD, FACS
University of California, San Francisco
William R. Ryan, MD, FACS
University of California, San Francisco
Jennifer Bager, MD, FACS
Tripler Army Medical Center, Honolulu, HI

CONCURRENT COURSE!
American College of Surgeons Thyroid, Parathyroid, and Neck Ultrasound • February 18-19, 2018
COURSE CHAIRS
Marika Russell, MD and Jolie Chang, MD
Upcoming CME Courses

39th Annual Advances in Infectious Diseases: New Directions for Primary Care
Wednesday, March 14 – Friday, March 16, 2018
Holiday Inn Golden Gateway – San Francisco, California

Primary Care Medicine: Update 2018
Sunday, April 1 – Friday, April 6, 2018
Wailea Beach Marriott and Spa – Wailea, Maui, Hawaii

High Risk Emergency Medicine Hawaii 2018
Sunday, April 8 – Thursday, April 12, 2018
Wailea Beach Marriott and Spa – Wailea, Maui, Hawaii

Essentials of Women's Health:
An Integrated Approach to Primary Care and Office Gynecology
Sunday, July 1 – Friday, July 6, 2018
Hapuna Beach Prince Hotel – Kohala Coast, Hawaii

Neurosurgery Update 2018
Thursday, August 2 – Saturday, August 4, 2018
Silverado Resort, Napa, California

Sialendoscopy / Salivary Duct Surgery
Thursday, November 29, 2018
Head and Neck Cancer and Endocrine Surgery Update
Friday, November 30 – Saturday, December 1, 2018
JW Marriott Hotel – San Francisco, California

Pacific Rim Otolaryngology- Head and Neck Surgery Update
Saturday, February 16 – Tuesday, February 19, 2019
Moana Surfrider Hotel – Honolulu, Hawaii

All Courses Managed by:
UCSF Office of Continuing Medical Education
3333 California Street, Room 450, San Francisco, CA 94118
For information call: 415-476-4251
Visit the web site at cme.ucsf.edu
Acknowledgement of Commercial Support

This CME activity was supported in part by educational grants from the following:

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KLS Martin
Medtronic
NeilMed
Olympus America ENT Division
Pentax Medical
Smith & Nephew
Stryker
Summit Medical - Innovia Medical
Pacific Rim Otolaryngology – Head and Neck Surgery Update

With improved understanding of pathophysiology and disease mechanisms and with technological advancements, the approaches to head and neck surgical disorders and head and neck surgery techniques continue to evolve at a rapid pace. The goal of this course is to provide an update in contemporary head and neck surgery and to foster educational interaction between practitioners from the Pacific Rim and beyond.

This course is intended for practicing otolaryngologist-head and neck surgeons, facial plastic surgeons, oral and maxillofacial surgeons, dermatologic surgeons, and nurses.

Educational Objectives

An attendee completing this course should be able to discuss and, as appropriate, apply:

- The evidence and rationale behind lymph node management in thyroid cancer;
- The updated indications for the use of cochlear implants;
- Current options for management of frontal sinus fractures;
- Various rhinoplasty techniques for cosmetic and functional goals;
- Factors in the rehabilitation of music perception with cochlear implantation;
- Concepts of sleep apnea in the pediatric and adult populations;
- Current concepts on the management of unilateral vocal cord paralysis;
- Contemporary management of obstructive salivary disease;
- Medical practice website development;
- Migraine-related dizziness strategies.

Accreditation

The University of California, San Francisco School of Medicine (UCSF) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UCSF designates this live activity for a maximum of 22.75 AMA PRA Category 1 Credits™. Physician should claim only the credit commensurate with the extent of their participation in the activity.

This CME activity meets the requirements under California Assembly Bill 1195, continuing education and cultural and linguistic competency.

Trauma:
The approved credits shown above include 1.25 credits toward satisfying the American College of Surgeons Committee on Trauma requirement for trauma-related continuing medical education.

Nurses:
For the purpose of recertification, the American Nurses Credentialing Center accepts AMA PRA Category 1 Credit™ issued by organizations accredited by the ACCME.

Physician Assistants:
AAPA accepts Category 1 Credit from AOACCME, Prescribed credit from AAFP, and AMA Category 1 Credit™ from organizations accredited by the ACCME.
General Information

**Attendance Verification/Sign-In Sheet**

Please remember to sign-in on the sign-in sheet when you check in at the UCSF Registration Desk on your first day. You only need to sign-in once for the course, when you first check in.

**Speaker Survey- Electronic**

On Friday, February 16th, you will receive an email from Qualtrics@ucsf.edu with a personalized link to access the Speaker Survey. Please make sure that you add this email to your safe senders list. This year the survey will be completed online for added convenience. If you did not receive the link, please see the UCSF Registration Desk.

The Speaker Survey is to be completed in real time during the course and is separate from the Evaluation/CME Certificate.

**Evaluation / CME Certificates**

On the last day of the course, you will receive an email from Qualtrics@ucsf.edu with a personalized link to complete your online Course Evaluation/ CME Certificate. Please make sure that you add this email to your safe senders list. The Qualtrics system will send you reminders to complete your Evaluation/CME Certificate until you complete it.

Upon completion, your CME certificate will be automatically generated to print and/or email yourself a copy. For smartphone users, you may want to take a photo of your certificate as some settings prevent you from emailing the certificate.

The link will be available for 30 days after the last day of the course. However, after that date the link will expire and you will no longer be able to claim your credits online.

You must then contact the Office of CME at registration@ocme.ucsf.edu to receive your certificate and a $15 administrative fee may be applied.

**Lunch**

The course will conclude at lunchtime each day with the exception of Monday. Lunch is on own each day and a list of restaurants is available through the Moana Surfrider concierge staff.

**Security**

We urge caution with regard to your personal belongings. We are unable to replace these in the event of loss. Please do not leave any personal belongings unattended in the meeting room.

**Exhibits**

Industry exhibits will be available outside the General Session room during course breakfasts and breaks.

**Case Discussions**

Each day of the course there will be an opportunity to discuss various cases along with light refreshments.

**Reception**

The course reception will take place on Monday evening from 7:00PM- 9:00PM on the Diamond Terrace and is open to the paid attendee and one adult guest. You will receive tickets for you and your guest when you arrive at the reception.

Please note that the location is subject to change due to weather and we will make an announcement if there is a location change.
Federal and State Law
Regarding Linguistic Access and Services for Limited English Proficient Persons

I. Purpose.
This document is intended to satisfy the requirements set forth in California Business and Professions code 2190.1. California law requires physicians to obtain training in cultural and linguistic competency as part of their continuing medical education programs. This document and the attachments are intended to provide physicians with an overview of federal and state laws regarding linguistic access and services for limited English proficient (“LEP”) persons. Other federal and state laws not reviewed below also may govern the manner in which physicians and healthcare providers render services for disabled, hearing impaired or other protected categories.

The Federal Civil Rights Act of 1964, as amended, and HHS regulations require recipients of federal financial assistance (“Recipients”) to take reasonable steps to ensure that LEP persons have meaningful access to federally funded programs and services. Failure to provide LEP individuals with access to federally funded programs and services may constitute national origin discrimination, which may be remedied by federal agency enforcement action. Recipients may include physicians, hospitals, universities and academic medical centers who receive grants, training, equipment, surplus property and other assistance from the federal government.

HHS recently issued revised guidance documents for Recipients to ensure that they understand their obligations to provide language assistance services to LEP persons. A copy of HHS’s summary document entitled “Guidance for Federal Financial Assistance Recipients Regarding Title VI and the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons – Summary” is available at HHS’s website at: http://www.hhs.gov/ocr/lep/.

As noted above, Recipients generally must provide meaningful access to their programs and services for LEP persons. The rule, however, is a flexible one and HHS recognizes that “reasonable steps” may differ depending on the Recipient’s size and scope of services. HHS advised that Recipients, in designing an LEP program, should conduct an individualized assessment balancing four factors, including: (i) the number or proportion of LEP persons eligible to be served or likely to be encountered by the Recipient; (ii) the frequency with which LEP individuals come into contact with the Recipient’s program; (iii) the nature and importance of the program, activity or service provided by the Recipient to its beneficiaries; and (iv) the resources available to the Recipient and the costs of interpreting and translation services.

Based on the Recipient’s analysis, the Recipient should then design an LEP plan based on five recommended steps, including: (i) identifying LEP individuals who may need assistance; (ii) identifying language assistance measures; (iii) training staff; (iv) providing notice to LEP persons; and (v) monitoring and updating the LEP plan.

A Recipient’s LEP plan likely will include translating vital documents and providing either on-site interpreters or telephone interpreter services, or using shared interpreting services with other Recipients. Recipients may take other reasonable steps depending on the emergent or non-emergent needs of the LEP individual, such as hiring bilingual staff who are competent in the skills required for medical translation, hiring staff interpreters, or contracting with outside public or private agencies that provide interpreter services. HHS’s guidance provides detailed examples of the mix of services that a Recipient should consider and implement. HHS’s guidance also establishes a “safe harbor” that Recipients may elect to follow when determining whether vital documents must be translated into other languages. Compliance with the safe harbor will be strong evidence that the Recipient has satisfied its written translation obligations.

In addition to reviewing HHS guidance documents, Recipients may contact HHS’s Office for Civil Rights for technical assistance in establishing a reasonable LEP plan.

The California legislature enacted the California’s Dymally-Alatorre Bilingual Services Act (Govt. Code 7290 et seq.) in order to ensure that California residents would appropriately receive services from public agencies regardless of the person’s English language skills. California Government Code section 7291 recites this legislative intent as follows:

“The Legislature hereby finds and declares that the effective maintenance and development of a free and democratic society depends on the right and ability of its citizens and residents to communicate with their government and the right and ability of the government to communicate with them.

The Legislature further finds and declares that substantial numbers of persons who live, work and pay taxes in this state are unable, either because they do not speak or write English at all, or because their primary language is other than English, effectively to communicate with their government. The Legislature further finds and declares that state and local agency employees frequently are unable to communicate with persons requiring their services because of this language barrier. As a consequence, substantial numbers of persons presently are being denied rights and benefits to which they would otherwise be entitled.

It is the intention of the Legislature in enacting this chapter to provide for effective communication between all levels of government in this state and the people of this state who are precluded from utilizing public services because of language barriers.”

The Act generally requires state and local public agencies to provide interpreter and written document translation services in a manner that will ensure that LEP individuals have access to important government services. Agencies may employ bilingual staff, and translate documents into additional languages representing the clientele served by the agency. Public agencies also must conduct a needs assessment survey every two years documenting the items listed in Government Code section 7299.4, and develop an implementation plan every year that documents compliance with the Act. You may access a copy of this law at the following url: http://www.spb.ca.gov/bilingual/dymallyact.htm
## Faculty List

### COURSE CHAIRMEN

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew H. Murr, MD, FACS</td>
<td>Professor and Chairman, Department of Otolaryngology-Head and Neck Surgery, University of California, San Francisco</td>
</tr>
<tr>
<td>William R. Ryan, MD, FACS</td>
<td>Associate Professor, Division of Head and Neck Oncologic and Endocrine Surgery, Salivary Gland Surgery and Sialendoscopy, University of California, San Francisco</td>
</tr>
<tr>
<td>Jennifer M. Bager, MD, FACS</td>
<td>Chief, Otolaryngology – Head and Neck Surgery, Tripler Army Medical Center- Honolulu, HI</td>
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### GUEST FACULTY

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<thead>
<tr>
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<tbody>
<tr>
<td>M. Boyd Gillespie, MD</td>
<td>Professor and Chairman, Department of Otolaryngology Head and Neck Surgery, University of Tennessee Health Science Center, Memphis, TN</td>
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<tr>
<td>Michael L. Hinni, MD</td>
<td>Professor and Chair, Department of Otolaryngology – Head and Neck Surgery, Mayo Clinic Arizona Phoenix/Scottsdale, AZ</td>
</tr>
<tr>
<td>Jeffrey D. Rawnsley, MD</td>
<td>Associate Clinical Professor, Fellowship Director, Facial Plastic Surgery, Department of Head and Neck Surgery, UCLA David Geffen School of Medicine Los Angeles, CA</td>
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### UCSF FACULTY

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<thead>
<tr>
<th>Name</th>
<th>Position and Affiliation</th>
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<tbody>
<tr>
<td>David E. Conrad, MD</td>
<td>Assistant Professor, Division of Pediatric Otolaryngology</td>
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<tr>
<td>Jonathan R. George, MD, MPH</td>
<td>Assistant Professor, Division of Head and Neck Oncologic and Endocrine Surgery</td>
</tr>
<tr>
<td>Andrew N. Goldberg, MD</td>
<td>Roger Boles, MD Endowed Professor in Otolaryngology Education and Vice Chair; Chief of Division of Rhinology, Sinus, and Skullbase Surgery</td>
</tr>
<tr>
<td>P. Daniel Knott, MD</td>
<td>Professor, Chief of Division of Facial Plastic, Aesthetic, and Reconstructive Surgery</td>
</tr>
<tr>
<td>Charles J. Limb, MD</td>
<td>Francis A. Sooy Professor of Otolaryngology-Head and Neck Surgery; Chief, Division of Otology, Neurotology and Skull Base Surgery; Director, Douglas Grant Cochlear Implant Center</td>
</tr>
<tr>
<td>Patricia A. Loftus, MD</td>
<td>Assistant Professor, Division of Rhinology and Skull Base Surgery</td>
</tr>
<tr>
<td>Matthew S. Russell, MD</td>
<td>Assistant Professor, Division of General Otolaryngology</td>
</tr>
<tr>
<td>Jeffrey D. Sharon, MD</td>
<td>Assistant Professor, Division of Otology, Neuro-otology, and Skullbase Surgery; Director of Balance and Falls Center</td>
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TRIPLER ARMY MEDICAL CENTER FACULTY

Mac Camacho, MD
Chief of Sleep Surgery and Medicine

Bryan Liming, MD
Pediatric Otolaryngology

Jared M. Theler, MD
Chief Facial Plastics and Reconstructive Surgery
Director, Cleft Palate and Craniofacial Team

Eric D. Wirtz, MD
Assistant Program Director, Otolaryngology – Head and Neck Surgery,
Disclosures

The following faculty speakers, moderators and planning committee members have disclosed NO financial interest/arrangement or affiliation with any commercial companies who have provided products or services relating to their presentation(s) or commercial support for this continuing medical education activity:

Jennifer M. Bager, MD  Patricia A. Loftus, MD
Mac Camacho, MD  Jeffrey D. Rawnsley, MD
David E. Conrad, MD  Matthew S. Russell, MD
Jonathan R. George, MD, MPH  Jeffrey D. Sharon, MD
P. Daniel Knott, MD  Jared M. Theler, MD
Bryan Liming, MD  Eric D. Wirtz, MD

The following faculty speakers have disclosed a financial interest/arrangement or affiliation with a commercial company who has provided products or services relating to their presentation(s) or commercial support for this continuing medical education activity. All conflicts of interest have been resolved in accordance with the ACCME Updated Standards for Commercial Support:

**Andrew H. Murr, MD, FACS**
- Stock Shareholder: IntersectENT
- Board Member: AONA (foundation)

**William R. Ryan, MD**
- Board Member: Olympus
- Board Member: Medtronic
- Consultant: Ziteo

**M. Boyd Gillespie, MD**
- Consultant: Cook Medical
- Grant/Research Support: ImThera
- Grant/Research Support: Olympus
- Grant/Research Support: Zelegent

**Andrew N. Goldberg, MD, MSCE**
- Stock Shareholder: Siesta Medical

**Michael L. Hinni, MD**
- Holder of Intellectual Property Rights: Karl Storz
- Honorarium Recipient: Plural Publishing

**Charles J. Limb, MD**
- Spouse is an Employee: Genentech
- Grant/Research Support: Advanced Bionics
- Board Member
- Consultant
- Grant/Research Support: Med-El Corporation
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- Advisor or Reviewer: Oticon Medical
- Consultant
- Board Member
- Stock Shareholder
- Consultant: Frequency Therapeutics

This UCSF CME educational activity was planned and developed to: uphold academic standards to ensure balance, independence, objectivity, and scientific rigor; adhere to requirements to protect health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and, include a mechanism to inform learners when unapproved or unlabeled uses of therapeutic products or agents are discussed or referenced.

This activity has been reviewed and approved by members of the UCSF CME Governing Board in accordance with UCSF CME accreditation policies. Office of CME staff, planners, reviewers, and all others in control of content have disclosed no relevant financial relationships.
# Course Program

**Saturday, February 17, 2018**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>6:30 AM</td>
<td>Registration and Continental Breakfast</td>
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<tr>
<td>6:55</td>
<td>Welcome and Announcements</td>
<td>Drs. Murr, Ryan, Bager</td>
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<tr>
<td>7:00</td>
<td>Surgical Anatomy of Salivary Ducts</td>
<td>Andrew H. Murr, MD</td>
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<tr>
<td>7:30</td>
<td>Ethical Considerations in ENT</td>
<td>Jennifer Bager, MD</td>
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<tr>
<td>8:00</td>
<td>Transoral Robotic Surgery For Oropharynx Carcinoma – Quality of Life Impact</td>
<td>William R. Ryan, MD</td>
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<td>8:30</td>
<td>Soft Palate Surgeries for Obstructive Sleep Apnea</td>
<td>Mac Camacho, MD</td>
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<tr>
<td>9:00</td>
<td>T  Facial Nerve: Latest Developments in Treatment Options</td>
<td>P. Daniel Knott, MD</td>
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<td>9:30</td>
<td>Coffee Break</td>
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<tr>
<td>10:00</td>
<td>Salivary Endoscopy for Non-Stone Disorders</td>
<td>M. Boyd Gillespie, MD</td>
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<td>10:30</td>
<td>Eustachian Tube Balloon Dilation: a Potential Game Changer</td>
<td>Charles J. Limb, MD</td>
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<tr>
<td>11:00</td>
<td>Bitcoin, Blockchain, and the Future of Medicine</td>
<td>Jared M. Theler, MD</td>
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<tr>
<td>11:30</td>
<td>Pediatric Sinusitis: Are Kids Just Small Adults?</td>
<td>Bryan Liming, MD</td>
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<tr>
<td>12:00 PM</td>
<td>Versatility of the Submental Flap in Head and Neck Reconstruction</td>
<td>Michael L. Hinni, MD</td>
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<tr>
<td>12:30</td>
<td>Adjourn</td>
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<tr>
<td>5:00</td>
<td>Afternoon Case Discussions</td>
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**Sunday, February 18, 2018**

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<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>6:30 AM</td>
<td>Continental Breakfast</td>
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<tr>
<td>6:55</td>
<td>Announcements</td>
<td>William R. Ryan, MD</td>
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<tr>
<td>7:00</td>
<td>Surgeon-performed Ultrasound For Salivary Diseases</td>
<td>William R. Ryan, MD</td>
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<td>7:30</td>
<td>2007-2017: What Has Changed Most in My Practice Since the End of Fellowship</td>
<td>P. Daniel Knott, MD</td>
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<tr>
<td>8:00</td>
<td>Epistaxis: Upping Your Game</td>
<td>Matthew S. Russell, MD</td>
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<td>8:30</td>
<td>You Did What?! Malpractice and Otology</td>
<td>Philip D. Littlefield, MD</td>
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<td>9:00</td>
<td>Upper Airway Stimulation for Obstructive Sleep Apnea</td>
<td>M. Boyd Gillespie, MD</td>
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<td>9:30</td>
<td>Coffee Break</td>
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<tr>
<td>10:00</td>
<td>Leslie Bernstein Lecture – Naturalness in Rhinoplasty: External versus Endonasal Approaches</td>
<td>Jeffrey D. Rawnsley, MD</td>
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<tr>
<td>11:00</td>
<td>Evidence-based Neck Dissection for Thyroid Cancer</td>
<td>Jonathan R. George, MD</td>
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<td>11:30</td>
<td>Cognitive Bias and the Surgeon’s “Sixth Sense”</td>
<td>Matthew S. Russell, MD</td>
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<tr>
<td>12:00 PM</td>
<td>Future Directions in Head and Neck Surgery: From De-escalation to Tissue Regeneration</td>
<td>Michael L. Hinni, MD</td>
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<td>12:30</td>
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T = Trauma Credit
### Monday, February 19, 2018

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>12:25 PM</td>
<td>Announcements</td>
<td>Jennifer M. Bager, MD</td>
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<tr>
<td>12:30</td>
<td>T Battle Royale: MMF Old School Arch Bars versus New School Hybrids</td>
<td>Jared M. Theler, MD</td>
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<td>1:00</td>
<td>Contemporary Management of Inverted Papilloma</td>
<td>Andrew N. Goldberg, MD</td>
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<td>1:30</td>
<td>Approach to Noisy Breathing in the Infant and Child</td>
<td>David E. Conrad, MD</td>
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<tr>
<td>2:00</td>
<td>How I (Almost) Stopped Worrying About Injuring the Facial Nerve</td>
<td>Philip D. Littlefield, MD</td>
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<tr>
<td>2:30</td>
<td>Treatment of Malignant Melanoma</td>
<td>Eric D. Wirtz, MD</td>
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<td>3:00</td>
<td>Coffee Break</td>
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<tr>
<td>3:30</td>
<td>Laryngotracheal Stenosis</td>
<td>M. Boyd Gillespie, MD</td>
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<td>4:00</td>
<td>Evaluation and Management of CSF Rhinorrhea</td>
<td>Patricia A. Loftus, MD</td>
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<td>4:30</td>
<td>“Inside Out” Anatomy in Transoral Surgery</td>
<td>Michael L. Hinni, MD</td>
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<tr>
<td>5:00</td>
<td>Reoperative Parathyroidectomy: Tips for Success</td>
<td>Jonathan R. George, MD</td>
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<td>5:30</td>
<td>Vestibular Testing: a Quick Guide to Indications, Utility, and Interpretation</td>
<td>Jeffrey D. Sharon, MD</td>
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<td>6:45</td>
<td>Adjourn</td>
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<tr>
<td>7:00 PM</td>
<td>Reception</td>
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### Tuesday, February 20, 2018

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>6:30 AM</td>
<td>Continental Breakfast</td>
<td>Andrew H. Murr, MD</td>
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<td>Andrew H. Murr, MD</td>
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<tr>
<td>7:00</td>
<td>T Management of Orbital Hematoma</td>
<td>Andrew H. Murr, MD</td>
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<td>7:30</td>
<td>Practical Tips on Management of HPV Positive Oropharyngeal Cancer</td>
<td>Eric D. Wirtz, MD</td>
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<tr>
<td>8:00</td>
<td>Snoring After Adenotonsillectomy: Now What?</td>
<td>David E. Conrad, MD</td>
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<tr>
<td>8:30</td>
<td>Inner Ear Therapy: Where Are We Now?</td>
<td>Charles J. Limb, MD</td>
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<td>9:00</td>
<td>Frontal Sinus Surgery – From Balloons to Obliteration</td>
<td>Andrew N. Goldberg, MD</td>
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<tr>
<td>10:00</td>
<td>Follicular Unit Extraction: Closing the Detectability Gap in Hair Restoration</td>
<td>Jeffrey D. Rawnsley, MD</td>
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<tr>
<td>10:30</td>
<td>Obstructive Sleep Apnea Phenotypes</td>
<td>Mac Camacho, MD</td>
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<tr>
<td>11:00</td>
<td>Practical Management of the Dizzy Patient</td>
<td>Jeffrey D. Sharon, MD</td>
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<tr>
<td>11:30</td>
<td>Olfactory Dysfunction - What Are the Treatment Options?</td>
<td>Patricia A. Loftus, MD</td>
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<td>12:00 PM</td>
<td>Evolving Indications and Techniques for Tonsillectomy in Children</td>
<td>Bryan Liming, MD</td>
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T = Trauma Credit
Salivary Gland and Duct Anatomy
Andrew H. Murr, MD, FACS

Objectives
1. Review the anatomy of the major salivary glands
2. Become familiar with submandibular duct anatomy from an oral cavity perspective in contrast from the more common Level 1 neck perspective
3. Be familiar with the LSD Classification: Lithiasis/Stenosis/Dilation

Overview
This lecture will incorporate a review of salivary gland and duct anatomy as well as the supporting nerve structures.

References
**Soft Palate Surgeries for Obstructive Sleep Apnea**
Macario "Mac" Camacho, MD

**Objectives**
1. Present the various types of soft palate surgeries that can be performed to treat snoring and obstructive sleep apnea.
2. Present the relationship between the soft palate/uvula and sleep disordered breathing.
3. Present the most up-to-date information on outcomes of soft palate surgeries as they pertain to obstructive sleep apnea.

**Overview**
This presentation summarizes the relationship that exists between soft palate tissue/uvula and sleep disordered breathing.

**Conclusions**
There is a relationship between snoring, obstructive sleep apnea and the soft palate/uvula. Targeted surgeries can help improve post-operative outcomes.
**Salivary Endoscopy for Non-Stone Disorders**
M. Boyd Gillespie, MD, MSc

**Objectives**
1. Learn which non-stone disorders are improved by salivary endoscopy
2. Understand techniques of salivary endoscopy to assist with non-stone disorders
3. Grasp expected outcomes of treating non-stone disorders with salivary endoscopy

**Overview**
Approximately 50% of patients presenting with salivary swelling and discomfort from non-neoplastic sources have a non-stone disorder. Salivary endoscopy can play a role in the diagnosis and management of these patients, however a thorough understanding of the underlying disorder is needed in order to properly manage these patients from a medical and surgical standpoint.

**Conclusions**
Salivary endoscopy can reduce the frequency and severity of symptoms from non-stone disorders, although ongoing management is required for most patients.

**References**

**Upper Airway Stimulation for OSA**
M. Boyd Gillespie, MD, MSc

**Objectives**
1. Learn which patients are eligible for upper airway stimulation (UAS)
2. Understand technical details of UAS surgery and management
3. Learn expected long-term outcomes of patients undergoing UAS

**Overview**
OSA is a prevalent disorder that increases cardiovascular morbidity and mortality. CPAP is the first-line treatment, however up to 1/3 of patients are unable to tolerate CPAP long-term. UAS is a novel, effective therapy for select patients with OSA who cannot tolerate CPAP therapy.

**Conclusions**
UAS is a promising therapy for patients with moderate to severe OSA who cannot tolerate CPAP. Long-term sleep study and patient-based outcomes are encouraging.

**References**
Bitcoin, Blockchain and the Future of Medicine
Jared M Theler MD

Objectives
1. Introduce the history of bitcoin and the current technology that powers it, blockchain
2. Discuss the current changes occurring within multiple industries due to blockchain and how this will bleed over into medicine.
3. Discuss how this new technology has the power to affect how research is performed, medical data is stored and health care is delivered.

Overview
Bitcoin quietly entered the technology and currency scene in 2009 in response to the effects of the 2008 worldwide financial crisis. While in the past it has been derided by many as a curiosity of the techno-geeks, the libertarian idealist or the dark web crawlers; 2017 was the year it went mainstream. Although Bitcoin receives all the headlines; it’s blockchain (the technology behind it) that has the potential to upend many industries in the coming decades.

Blockchain in its simplest description is an immutable ledger (think huge excel sheet) distributed across many nodes throughout the world. This distributed cryptographic ledger technology will change many transactional industries. While currency and the financial sector will be the first to be affected, medicine will not be very far off behind.

We will attempt to define some of the basic concepts of blockchain such as merkel trees, distributed autonomous organizations, smart contracts and other alternative cryptocurrencies/tokens. In addition a review of some of the more novel current technologies built on these concepts such as Ethereum, Gnosis, Ripple and patientory will be discussed.

To conclude I will discuss current and future projects on the horizon within healthcare. Blockchain will likely be used to leverage future research protocols and big data. Patient data storage will also be affected by blockchain and will allow for more secure and universally available EMR’s. A summary of this potential future will be provided.

Conclusions
Bitcoin and Blockchain (the technology that power it) are here to stay. In the coming years we will see significant changes to the healthcare industries because of blockchain. Those who learn to leverage and embrace it early, have the opportunity to effect dramatic changes within their realm of influence.
Pediatric Sinusitis: Are kids just small adults?
Bryan J. Liming, MD

Objectives
1. Discuss diagnostic considerations in children with chronic and recurrent acute sinusitis.
2. Discuss medical and surgical management of pediatric chronic sinusitis.
3. Discuss role of allergy testing and treatment in pediatric chronic sinusitis.

Overview
This lecture will discuss the diagnostic considerations and medical and surgical management of pediatric chronic sinusitis.

Conclusions
Pediatric chronic sinusitis has unique features that differentiate it from adult chronic sinusitis.

References
TBD
Versatility of the Submental Flap in Head and Neck Reconstruction
Michael L. Hinni, MD

Objectives
1) Describe the advantages of the submental flap over free tissue transfers
2) Describe the possible dimensions of the submental flap
3) Describe the vascular anatomy and variations encountered during flap elevation

Overview
The submental pedicled flap is a useful flap that can be placed into the oral cavity, on the external face or neck, into the oral cavity or oropharynx, esophagus, and can be used for the total pharyngectomy reconstruction. It allows a single wound without donor site morbidity or secondary grafting and generally eliminates the need for microvascular reconstruction. With careful flap elevation, this useful flap can be used in a general otolaryngology head and neck surgery practice. The anatomy is straightforward. Multiple case examples will be shared.

Conclusions
The Submental flap is easy to harvest, and can largely eliminate the need for soft tissue free flaps for most head and neck defects.
Sialendoscopic Assisted Salivary Duct Surgery: Durability of Outcomes
William R. Ryan, MD

**Obstructive Sialadenitis**
Sialoliths—> Extraction
Stenoses—> Dilation / Bypass (Sialodochoplasty)
Sialadenectomy can be used for both

**Findings -> Treatment Expectations**
**Sialoliths -> 4 -7mm:** Open/Combined
**Distal Duct Disease:** Transoral and/or Sialendoscopy
**Proximal Duct Disease:** Transoral and/or Sialendoscopy or Transfacial Combined
**Parenchymal Duct Disease:** Transfacial Combined or Sialadenectomy

Multiple Video Demonstration

**COSS Questionnaire**
20 sialadenitis-specific questions (0-10 scores)
0-100 total possible

**Sialoliths after Sialendoscopic Assisted Salivary Duct Surgery**
Statistically significant reductions with complete resolution
42% endoscopic only retrieval

**Non-sialolith after Sialendoscopic Assisted Salivary Duct Surgery**
Statistically significant reductions with partial resolution
New Data with 1-year follow up
Durability of effect post-operatively from 3-month to 1-year for:
- Sialoliths
- Stenoses
- RAI Induced Sialadenitis

**CONCLUSIONS**
- Sialendoscopy (and Surgeon-Performed Ultrasound) Are Useful For Chronic Obstructive Sialadenitis
- Follow an Algorithmic Approach
- Develop Experience with the Various Tools
- Be Prepared For Combination Approaches (Endoscopic – Assisted)
- Establish Expectations With Outcomes Evidence
Naturalness in Rhinoplasty
Jeffrey Rawnsley, MD, MS

Overview
Emphasis in rhinoplasty surgery education tends towards surgical technique, detail and innovation. Patients tend to focus on the results of surgery, as it is their primary interest. These factors including symmetry, aesthetic balance, naturalness and an absence of the stigmata of surgery. Surgeons must understand how their technique and perception affect their results, and ultimately patient satisfaction. The role of endonasal rhinoplasty in reducing operative distortions will be discussed.
Evidence-Based Neck Dissection for Thyroid Cancer
Jonathan George, MD, MPH

Objectives
1. To review current and prior literature regarding the role of central & lateral neck dissection in thyroid cancer.
2. To explore the controversy surrounding elective central neck dissection.
3. To review helpful techniques for successful central & lateral neck dissection surgery.

Overview
Papillary thyroid cancer has a proclivity to nodal metastasis in the central and lateral neck. Neck dissection therefore plays an important role in the regional control of this disease. Controversy remains regarding the role of central neck dissection (CND), however. We will review the evidence in support of elective CND, as well as the arguments against it, and the data regarding the role of lateral neck dissection. Tips regarding helpful surgical technique will be made as well.

Conclusions
Central neck dissection (CND) for well-differentiated thyroid cancer remains controversial. The data reviewed provide support for elective central neck dissection under certain circumstances, but also indicate that elective CND is not without risk of real morbidity. Surgical techniques reviewed may facilitate safe neck dissection, even in the reoperative setting.
Future Directions in Head and Neck Surgery: De-escalation to Regeneration
Michael L. Hinni, MD

Objectives
1. Recognize the ongoing research into reducing adjuvant radiation dosing in HPV positive Squamous Cell Carcinoma
2. Recognize the reduced morbidity with endoscopic surgical techniques
3. Recognize the state of the art in tissue engineering and 3D printing on head and neck reconstruction.

Overview
The introduction of transoral laser surgery to head and neck cancer resections has reduced morbidity and hospital stay. Subsequent interest generated by the surgical robotic platforms and newer laser wavelengths besides CO2 have also moved the field of forward, reducing morbidity and permitted some cancers to be treated in the office setting. We are on the cusp of tremendous improvements in tissue engineering and regeneration that may permit, when necessary, real time reconstructions of organs or parts of organs with biologic templates and induced stem cells or 3D printed organs.

Conclusions
The evolving field of Regenerative Medicine brings many excitements for the care of the head and neck patient and care team alike.

References
Contemporary Transoral Surgery for Primary Head and Neck Cancer, Michael Hinni and David Lott, Plural Publishing, Inc., 2015
Battle Royal: MMF vs Hybrid Systems
Jared M Theler MD

Objectives
1. Provide a brief description of the different current forms of MMF.
2. Compare and contrast their different advantages and disadvantages.
3. Summarize the best systems for different scenarios

Overview
Erich Arch Bars have been the gold standard for the treatment of mandible fractures for the previous 60 years. Over the past three decades ORIF has brought new alternatives for treatment of mandible fracture, while MMF has remained mostly the same. In the prior 10 years, new methods of MMF have come to market to include embrasure wires, IMF screw and hybrid systems.

The new hybrid systems such as The Wave have the advantage of providing good MMF without the need for ideal dentition and can be applied in a much shorter time. However they also come with a significantly increased raw material cost and risk for tooth root injury. It also remains to be seen if they can be applied to more complex fractures effectively.

We will attempt to answer ten basic questions in regards to the different MMF methods:
1 - What is the estimated monetary cost of each system? (this could be broken down into cost of OR time and/or direct cost to purchase)
2 - What is the estimated time for application/placement?
3 - How is ease of removal (time, patient comfort, OR required)?
4 - What is the rate/risk of dental root/crown injury?
5 - What is the risk of gingival recession/injury?
6 - Are there relative or FDA assigned contraindications for each system?
7 - What is the most common cause of system failure?
8 - How does it perform in a patient with poor dentition?
9 - Can it be used for complex comminuted fractures of the mandible?
10 - Can it be used with both mandibular and lefort fractures?

Conclusions
Erich arch bars are and will remain the gold standard for MMF in most cases. Embrasure wires can be used in many simple fractures for intraoperative fixation with plan for ORIF in the case of good dentition. The rate of tooth root injury from screws for IMF and hybrids systems cannot be underestimated, but can be reduce by avoiding pilot hole drilling and using self-drilling/self-tapping screws. When time is of the essence, hybrid systems can be used in most cases for comminuted and complex fractures.

References
1 Level I trauma center value analysis assessment (UC Davis)
5 Farber SJ, Snyder-Warwick AK, Skolnick GB, Woo AS, Patel KB. Maxillomandibular fixation by plastic surgeons. Ann Plast Surg 2016;77:3
Approach to the Noisy Breathing in the Infant and Child
David Conrad, MD, FAAP

Objectives
1. Developing a differential for noisy breathing and stridor
2. Discuss the diagnostic modalities beyond fiberoptic laryngoscopy
3. Review common causes of noisy breathing in the infant and appropriate workup
4. Croup: When does a child need a bronchoscopy?
5. How reflux does and does not play a role in worsening airway pathology
6. Laryngomalacia: medical management and observation versus supraglottoplasty
7. Develop an algorithm to identify patients who would benefit most from diagnostic airway evaluation

Overview
Evaluating noisy breathing in children remains a challenge given the large differential for snoring and stridor. A systematic approach is helpful to identify patients most at risk for more serious airway pathology and avoid anesthesia in patients who are relatively low risk. Patient history and exam remain powerful indicators for localizing the site(s) of obstruction, however the decision when to perform a bronchoscopy can be difficult and the outcome of undiagnosed airway pathology can result in serious harm. This lecture discusses common causes of noisy breathing, and a comprehensive functional approach to evaluation. Snoring and Laryngomalacia will be discussed in detail, as well as the utility of diagnostic laryngoscopy and supraglottoplasty. While supraglottoplasty is most often considered for refractory cases, there is some data to suggest it is underutilized in borderline candidates. Children with a history of prematurity and Trisomy 21 may often require a formal airway examination under anesthesia to rule out synchronous airway pathology, since there is a higher rate of failure after supraglottoplasty. In particular, recurrent croup poses a diagnostic dilemma for surgeons considering bronchoscopy. In general, history of prematurity, young age and intubation remains the strongest predictive factors for patients with airway stenosis. Noisy breathing in infants and children remains challenging; it is helpful to apply an evidence-based systematic diagnostic approach to identify patients who would benefit most from diagnostic airway evaluation under anesthesia.

Conclusions
Noisy breathing in infants and toddlers is common and poses a challenge to surgeons wishing to minimize exposure to anesthesia in young children. History and physical examination remain among the most important components of assessment, and may often localize the site of airway obstruction. History of intubation, prematurity and younger age are among the most predictive for more serious airway pathology that requires bronchoscopy. It is important to use other diagnostic modalities when possible, and apply an evidence-based approach to children when considering airway endoscopy under anesthesia.
References


Treatment of Malignant Melanoma
Eric D Wirtz, MD

Objectives
1. Discuss updates in surgical management of melanoma
2. Discuss current adjuvant therapy for melanoma
3. Highlight clinical trials for metastatic melanoma

Overview
Discuss recent updates in surgical staging and management of melanoma. Discuss current trends in adjuvant treatment of metastatic melanoma as well as highlight current clinical trials for treatment of metastatic melanoma.

Conclusions
N/A
Laryngotracheal Stenosis: Current Management Strategies
M. Boyd Gillespie, MD, MSc

Objectives
1. Understand factors related to the increase in laryngotracheal stenosis (LTS)
2. Learn appropriate evaluation of patients with LTS
3. Review updated surgical techniques for managing LTS

Overview
Laryngotracheal stenosis (LTS) is a difficult disorder that is increasing in incidence due to a variety of factors. Goals of therapy are to allow patients to have normal function of airway and swallowing without a tracheotomy. A comprehensive approach to these patients using a variety of new and established techniques can accomplish these goals in most patients.

Conclusions
LTS is a disorder that is treatable and can allow a tracheostomy-free life. Proper patient and procedure selection are keys to successful outcome.

References
Evaluation and Management of CSF Rhinorrhea
Patricia A Loftus, MD

Objectives
1. Discuss the classification system for the different etiologies of cerebrospinal fluid (CSF) rhinorrhea
2. Review the important anatomy associated with CSF leak
3. Describe the clinical presentation of patients with CSF rhinorrhea
4. Discuss the evaluation and workup of patients with CSF rhinorrhea
   a. History
   b. Examination → nasal endoscopy
   c. Confirmation → Beta-2 transferrin
   d. Localization → Imaging (high resolution CT, MRI/CT cisternogram)
   e. Review an evidence-based algorithm for diagnosis of CSF rhinorrhea
5. Describe the management of different etiologies of CSF leak
   a. Conservative/Medical → bed rest, lumbar drain, acetazolamide
   b. Surgical → many, many ways to repair
      i. Discuss the use of intrathecal fluroscein
6. Discuss perioperative management/considerations in patients with CSF rhinorrhea
   a. Antibiotics?
   b. Lumbar drain?
7. Describe outcomes following surgical repair of CSF leak

Overview
CSF rhinorrhea, although rare in the general population, is encountered in otolaryngology practices. CSF rhinorrhea is classified into traumatic and non-traumatic leaks, with the former making up the majority of cases. However, more recent data suggests that spontaneous rhinorrhea (aka idiopathic or non-traumatic leaks) may be more common than previously thought, ranging from 30-40% of patients with CSF leak. Spontaneous CSF rhinorrhea is thought to be associated with elevated intracranial pressures (i.e. idiopathic intracranial hypertension), specifically in the obese population. Patients presenting with clear, mostly unilateral rhinorrhea should be worked up for CSF leak. This lecture will review the most recent evidence-based algorithm for the diagnosis and localization of CSF leak in this patient population. For spontaneous CSF rhinorrhea, management is surgical, and closure of the leak should occur promptly to avoid dangerous sequelae such as meningitis. This lecture will also focus on the perioperative management and surgical techniques for closure of CSF leaks in patients presenting with idiopathic CSF rhinorrhea.

Conclusions
Although rare in the general population, CSF rhinorrhea is encountered in otolaryngology practices. Prompt and thorough workup should be based on current evidence-based recommendations, which include both diagnostic testing for a definitive diagnosis as well as radiographical localization of the leak to guide surgical management. In our current population, spontaneous CSF rhinorrhea may become more common, and an understanding of the diagnosis and management of this disorder is important to all practicing otolaryngologists.
References

“Inside Out” Anatomy in Transoral Surgery  
Michael L. Hinni, MD

**Objectives**
1. Recognize the risks of bleeding in transoral surgery
2. Articulate how to identify the major branches of the external carotid system in transoral surgery
3. Describe the critical muscular anatomy in the lateral pharynx and larynx from the endoscopists perspective

**Overview**
Transoral laser and robotic approaches to head and neck tumors are becoming increasingly common alone or in combination with de-escalation protocols throughout the western world. The added benefits and reduced morbidity is not without some new risks however, and deaths from bleeding have been reported. This lecture describes the critical anatomy with pearls to identify and control vascular structures during Transoral Surgery.

**Conclusions**
Understanding the true “inside out” anatomy during transoral resections is key to avoiding complications.

**References**
**Reoperative Parathyroidectomy**
Jonathan George, MD

**Objectives**
1. Review the diagnostic workup for recurrent hypercalcemia following parathyroidectomy for primary hyperparathyroidism.
2. Take a detailed look at the imaging modalities most helpful for localization of parathyroid adenomata in recurrent hyperparathyroidism.
3. Discuss helpful surgical techniques for parathyroid localization in the reoperative setting.

**Overview**
Recurrent hypercalcemia following parathyroidectomy is uncommon but presents important clinical management dilemmas. Establishing the diagnosis of recurrent hyperparathyroidism is a critical feature to precede the decision for surgery. Imaging modalities vary in sensitivity and specificity. Reoperative parathyroidectomy carries risks of substantial morbidity, so helpful techniques for successful surgery will be reviewed.

**Conclusions**
Diagnostic considerations are paramount in the setting of recurrent hypercalcemia following parathyroidectomy. Reoperation carries substantial risk and requires confirmed diagnosis and need for surgery; utilization of more than one imaging modality; and safe techniques for successful surgery.
Vestibular Testing: A Quick Guide to Indications, Interpretation, and Utility
Jeffrey D. Sharon, MD

Objectives
1. Learn about the physiology of vestibular testing
2. Understand indications for ordering different types of vestibular testing, including video head impulse testing, rotary chair testing, videonystagmography, vestibular evoked myogenic potentials, and posturography
3. Understand how to interpret the results of vestibular testing

Overview
This course will present:
- Some general thoughts on vestibular testing
- A brief review of physiology necessary to understand vestibular testing
- An overview on the indications, contraindications, and interpretation of:
  - video head impulse testing
  - rotary chair testing
  - videonystagmography
  - vestibular evoked myogenic potentials
  - posturography

Conclusions
With a good understanding of physiology, and the indications and interpretation of vestibular testing, one will be able to utilize it effectively in the care of vestibular patients.

References
1-6
Management of Orbital Hematoma
Andrew H. Murr, MD, FACS

Objectives
1. Understand anatomical factors that relate to orbital hematoma
2. Identify medications that can be used to lessen the effects of orbital hematoma
3. Incorporate surgical steps that can be used emergently to treat orbital hematoma

Overview
This lecture will help surgeons to identify the causes and various types of orbital hematoma, protocols to prevent them, and management strategies.

References
3. Microdebrider- Lx, 2011(121):2684 (Stankiewicz)
4. Lx, 2011(121):2684
Practical Tips on Management of HPV Positive Oropharyngeal Cancer
Eric D Wirtz, MD

Objectives
1. Recap current prognostic implications of HPV positive cancer
2. Discuss recurrence patterns and their differentiation from HPV negative cancer
3. Discuss implications on cancer surveillance on HPV positive cancer

Overview
Discuss prognostic implications of HPV positive cancer and its implications on cancer surveillance. Discuss recurrence patterns and way to tailor your practice for HPV positive patients.

Conclusions
N/A
Snoring After Adenotonsillectomy: Now What?
David Conrad, MD, FAAP

Objectives
1. Identifying patients at risk for postsurgical snoring and sleep disordered breathing (SDB)
2. Interpreting Polysomnography: AHI and oxygen saturation are not everything
3. Review the role of medical management for persistent postsurgical snoring and sleep disturbances
4. When to consider revision surgery versus medical management and adjunct therapy
5. Discuss the natural history of SDB, when will patients ‘outgrow’ the disorder?

Overview
Approximately 30-40% of patients who undergo adenotonsillectomy will fail to normalize their postoperative apnea-hypopnea index (AHI). It is important to identify patients at risk for postsurgical failure to counsel families appropriately when considering surgery. In particular, children with obesity, oro-maxillofacial dysmorphism, Trisomy 21 and comorbid hypotonia pose a challenge in obtaining complete cure of sleep disordered breathing via adenotonsillectomy. Medical management remains an excellent option for patients who fail to respond adequately to surgery. While many studies examining Montelukast and nasal steroids lack randomization, a Cochrane review showed successful reduction in postoperative AHI following 6 weeks of therapy. There is excellent data to support a large reduction in AHI with Montelukast in particular. Given their safety profiles, these medications should be strongly considered in non-responders. Patients with concomitant dental crowding and retrognathia may be referred for consideration of palate expansion, orthodontia and mandibular distraction depending on maxillofacial morphology. While revision surgery remains an option for patients with adenotonsillar regrowth, it is important to apply an evidence-based algorithm to minimize additional exposure to anesthesia if possible.

Conclusions
Preoperative assessment and patient selection is important when considering adenotonsillectomy. Identifying patients at risk for postsurgical failure will allow the surgeon to realistically set expectations and counsel families appropriately. Leukotriene antagonists and medical management remains an excellent option for patients with persistent snoring after surgery. While revision surgery remains a possibility for patients with persistent sleep disordered breathing, medical management and adjuvant therapies can often be successful in reducing symptoms and postsurgical AHI to an acceptable level.
References
10. Louise M. O'Brien, P.C.R.H., MAT, RPSGT*; Carolyn B. Mervis, PhD†; Carrie J. Klaus*; Jennifer L. Bruner, BSc*; Troy J. Raffield, MA‡; Rochelle C. Mehl, PhD‡; Mei Wang, PhD*; Andrew Tuell, BA*; Brittany C. Hume*; and David Gozal, MD*, *Sleep and Neurobehavioral Characteristics of 5- to 7-Year-Old Children With Parentally Reported Symptoms of Attention-Deficit/Hyperactivity Disorder*. Pediatrics, 2003. 111(3).
Follicular Unit Extraction in Hair Transplantation
Jeffrey Rawnsley, MD, MS

Overview
Modern hair transplantation involves recreating the natural follicular unit distribution in density-sparse areas of the scalp. The results are enhanced by proper design of the hairline, precise orientation of the grafts, and dense packing of the sites. The use of follicular unit extraction of the grafts improves undetectability in the donor area, though limitations exist.
Obstructive Sleep Apnea Phenotypes
Macario "Mac" Camacho, MD

Objectives
1. Present evidence for major phenotypes that can be used to classify patients who have OSA.
2. Present evidence for surgical management of OSA patients using the phenotype system.
3. Present why target-specific surgeries will improve outcomes.

Overview
There have been several studies that describe outcomes for the management of snoring and OSA.

Conclusions
There obstructive sleep apnea phenotype classification system can help direct sleep surgeries and may potentially improve sleep disordered breathing outcomes.
Practical Management of the Dizzy Patient
Jeffrey D. Sharon, MD

Objectives
1. Learn a quick and practical methodology for diagnosing the most common causes of dizziness based on key elements in the patient's history and a focused physical exam
2. Understand indications for ordering ancillary testing in the workup of vestibular disorders
3. Learn the initial treatment strategies for the most common causes of dizziness

Overview
This course will present:
- Some general thoughts on dizzy patients
- Epidemiology of vestibular disorders
- Formulating a differential diagnosis based on useful information in the HPI
- Key elements of the vestibular exam, including the head impulse test and the Dix-Hallpike maneuver
- Indications for ancillary testing, including vestibular testing and neuroimaging
- A quick overview of evidence-based treatments for 8 causes of dizziness
- Advice regarding the treatment of dizziness

Conclusions
With a good understanding of vestibular disorders, most patients with common causes of dizziness will be able to be diagnosed and treated

References
Olfactory Dysfunction - What Are the Treatment Options?
Patricia A Loftus, MD

Objectives
1. Discuss the importance of olfaction and the implications of smell loss
   a. Enjoyment of life: flavors, memories, social interactions, occupation
   b. Safety: spoiled food, smoke/fire, gas leaks, toxins
   c. Symptom of underlying disease process: neurologic, endocrine, tumor, malnutrition
2. Discuss the prevalence of olfactory dysfunction (OD)
3. Review the basic anatomy of olfaction
4. Describe the relationship between smell and taste
5. Discuss the evaluation of smell loss
   a. History
   b. Examination → nasal endoscopy
   c. Smell testing → understand how to interpret the results
   d. Imaging → when/if indicated
6. Review the definitions of different types of OD and the etiologies of smell loss
   a. Characterize etiologies as conductive or neurosensory loss
   b. Recognize when smell loss may be related to a more serious neurologic disorder such as Parkinson’s disease
7. Understand different treatment options and their limitations
   a. Preventative: educate patients regarding functioning smoke alarms, labeling perishable food with dates, etc.
   b. Medical (e.g., corticosteroids)
   c. Surgical (e.g., nasal polypectomy)
   d. Specifically, learn how to educate patients about olfactory training

Overview
OD affects 1-2% of the North American population (National Institute on Deafness and Other Communication Disorders) and 24.5% (15 million) of Americans over the age of 55 (National Institute on Aging, National Institutes of Health). Smell disorders result in diminished quality of life and safety concerns for those affected. An otolaryngologist may be the first physician to evaluate patients with smell loss, and therefore it is important that we as a specialty understand the classification, workup, and treatment options for smell loss in order to deliver the best possible care to these patients. This lecture includes a discussion about the importance of olfaction, its relationship to taste, the basic anatomy of olfaction, and the different etiologies of smell loss (upper respiratory infection, nasal polyps, head trauma, medications, idiopathic, etc). This lecture also focuses on the office evaluation and diagnostic workup for patients with smell loss, and reviews the available treatment options. Specific to treatment, we will discuss how to educate patients with smell loss about the option of olfactory training.

Conclusions
Smell disorders are common, and can significantly affect patients’ quality of life and put their safety at risk. Otolaryngologists may be the first physicians to evaluate and treat patients with olfactory disorders, and therefore it is paramount that we as a specialty have a good understanding of the etiologies of smell loss and the best treatment options currently available.
References