Nose news UPDATE

American Rhinologic Society - Volume 22:3 Summer 2003

Don Lanza, MD, FARS
President

It is great to be involved with this Society in 2003! The ARS winter Board of Directors (BOD) meeting in Chicago was very successful and many new initiatives are underway. The spring ARS meeting at the Gaylord Opryland Resort and Convention Center in Nashville begins Friday, May 2nd at 1 pm and is bound to be outstanding. Jim Hadley, ARS president–elect and program chair has requested each discussant to prepare questions for our new audience response system during the Saturday morning program. Our COSM poster session will surpass any prior ARS meetings in number and quality. During the Nashville meeting, we will grant the ARS Research Award for the best bench research submitted this year.

and AAO-HNS representatives seized the opportunity to fight for additional non-physician time allocated in association with endoscopic procedures. Examples of this are the additional nursing time required to coordinate care with neurosurgery for endoscopic cerebrospinal fluid leak repair and non-physician patient counseling for endoscopic procedures. Little ground could be gained however, despite robust efforts, since the PEAC had unilaterally decided to standardize non-physician time for all surgical procedures, in all specialties, with 0 and 10 day global periods.

If you are interested in becoming more active in the ARS we can use your help in many ways. Our educational committee, chaired by Winston Vaughan, MD needs otolaryngologists to work in conjunction with the Sinus and Allergy Health Partnership (SAHP). The SAHP requests otolaryngologists to give community lectures to primary care physicians and their residents on nasal and sinus disease. This outreach program is intended to elevate the overall standard of care for our patients. A slide lecture series from the SAHP is available to serve as the foundation for these educational presentations. Additionally, a modest honorarium is available from the SAHP for those who devote their time and efforts to this outreach program. For more information please send an email letter of interest and your curriculum vitae to Will Shawver, at shawver@sahp.org . If you are interested in becoming involved in the ARS in other ways please let me know directly at lanzad@ccf.org .

Lastly, if you have not yet renewed your membership, log on to www.american-rhinologic.org and receive a 10% discount for online membership renewal. While at our website be sure to determine if you are eligible to become a Fellow of the ARS.

I look forward to seeing you in Nashville for an outstanding meeting!

ARS 1954-2004: Fifty Years of Rhinology

The Annual ARS meeting will be hosted on Saturday, September 20th at the Peabody Hotel in Orlando, FL. As a result of Martin Citardi's relentless efforts, we plan to have online registration for this meeting. Our Cottle Award and our second International Research Award will be offered in September. Accepted posters and paper abstracts are eligible for this award and these manuscripts should be submitted to Allen Seiden, MD for his committee to review by August 1st. For more information, log onto www.american-rhinologic.org .

Please remember to look for the announcements regarding online registration to our Second Annual ARS CME Dinner Symposium on Saturday evening September 20th, 2003. This symposium, supported by a generous unrestricted educational grant from Merck, will focus on cutting edge technologies in rhinosinusitis and is being organized by our 1st vice president, Joe Jacobs. Additionally, Joe Jacobs, Jim Hadley, and Marv Fried are already working hard to prepare for our September 2004 Golden Anniversary in NYC. They have proposed a new ARS logo for this special celebration which is introduced in this newsletter.

Our Society continues to work on behalf the patients our membership serves. Specifically, in January, our Patient Advocacy Committee chair, Mike Sillers, MD attended the Practice Expense Advisory Committee (PEAC) meeting in Orlando with Teresa Lee, MPH and Peter Weber, MD of the AAO-HNS. As part of the AAO-HNS initiative to properly review practice expense issues, the ARS

Opryland: Site of the ARS Spring Meeting, May, 2003

ARS Spring Meeting
Gaylord Opryland
Nashville
May 2-3, 2003

Be Heard! Now Utilizing the Audience Response System

See Y'all in Nashville!

Mark Your Calendars Now for the ARS Fall Meeting
September 20, 2003
Orlando
Dinner Symposium sponsored by Merck

WHAT'S AHEAD?

March 15, 2003	*Abstract Deadline, ARS Fall Meeting*
March 21-23, 2003	*Cherry Blossom Conference, Rhinologic and Otologic Aspects of Skull Base Medicine and Surgery, Arlington, VA*
May 2-3, 2003	*ARS Spring Meeting, Nashville, TN*
August 1, 2003	*Deadline for Cottle Award Submission*
September 20, 2003	*ARS Fall Meeting, Orlando, FL*
October 23-26, 2003	*IRS/ISIAN Seoul, South Korea*

Patient Advocacy

Struggles & successes with PEAC

Michael Sillers, MD, FARS

The patient advocacy committee has recently combined efforts with the CPT committee to refine the practice expense component of the CPT codes used most frequently in the practice of rhinology. These efforts culminated in the presentation of consensus data to the Practice Expense Advisory Committee (PEAC) of the AMA in Orlando, FL January 27-29. These data were presented along with data from other subspecialty societies within our specialty as well as from all of medicine. AAO-HNS was well represented by Dr. Peter Weber who presented all these data formally to the PEAC. The process was time consuming, frustrating, and at times, seemingly consistently inconsistent. Each specialty is working to preserve their slice of the fixed reimbursement pie-any gains one specialty realizes translates into a loss by another specialty. Thankfully, all of our codes passed without major changes being made. Congratulations are in order for Peter Weber, M.D. and Teresa Lee, J.D., M.P.H., each of who worked tirelessly in representing our entire Academy.

The patient advocacy section on the ARS website has recently been reorganized in an effort to simplify access to committee updates as well as sample appeal letters for inappropriate claim denials. These letters are provided as a service to our membership in an effort to promote excellence in patient care. Should you meet with success or failure in your appeals process, please let us know. If you can suggest changes that would further assist the membership, we can utilize the ARS website to disseminate this information. If you have an interest in serving on the patient advocate committee in the future, please contact any of the committee members.

sinus & allergy health partnership

J. David Osguthorpe, MD, FARS

The Sinus and Allergy Health Partnership (SAHP) was launched in 1998, a cooperative effort of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), the American Academy of Otolaryngic Allergy (AAOA) and the American Rhinologic Society (ARS). The Partnership's initial efforts were outreach campaigns to primary care practitioners and the general public in order to counter the "Sinusitis Initiative" the American Academy of Allergy, Asthma and Immunology (AAAAI) had launched in 1997. As the AAAAI effort ran out of steam, the SAHP began to devote more activity toward scholastic pursuits and research. Recent activities of the SAHP are summarized as follows:

1. The "Professor-of-the Day" outreach to family medicine residencies has reached nearly 200 training programs, and over the upcoming year will be expanded to nurse practitioner programs, given research indicating that nurse practitioners, who are seeing an increasing number of patients in the U.S., are likely to utilize specialist consultation. The POD program has consisted of 2 "canned" 1-hour lectures, on rhinosinusitis and on allergic rhinitis, that will now being changed by J. Stankiewicz from the overview format of recent years to a problem patient-based format, in order to introduce new material to family medicine residencies that have previously hosted a POD.
2. The SAHP has developed, with input from the Centers for Disease Control and-Prevention and the Food and Drug Administration (FDA), a study that will compare direct maxillary sinus taps with endoscopically-directed middle meatal cultures in patients with bacterial rhinosinusitis. It is the hope of the SAHP that a concordance rate of 80-85% between direct maxillary taps and endoscopically-directed cultures can be demonstrated, and hence the FDA may allow such instead of requiring maxillary sinus taps for all phase II and III trials of antibiotics for rhinosinusitis. If so, otolaryngologists in the United States, in particular, should have a much better opportunity to participate in the sponsored trials.
3. In 2000 the SAHP published a "white paper" on "Antimicrobial Treatment Guidelines for Acute Bacterial Rhinosinusitis" (Otolaryngol Head Neck Surg, 2000;123:S1-S32), with over 250,000 copies distributed. An updated version is being planned for release in May 2003. A SAHP-organized Task Force is now studying chronic rhinosinusitis. Expect a publication to result within the next 12 months. The goal is to summarize the "state of the art" in acute and in chronic rhinosinusitis at the AAO-HNS "Cherry Blossom Conference" in the Spring of 2004 (plan to attend; contact AAO-HNS for registration).
4. The SAHP has revamped its website under the leadership of Dr. William Kinney, and such can be viewed at www.sahp.org. The website is now linked to our parent organizations, the AAO-HNS, AAOA and ARS.
5. A National Health Museum has been launched as a virtual site at www.nationalhealthmuseum.org, and plans for a physical site just off the Mall in Washington, DC are well under way. To "reserve" a place on both the web site and in the building, the SAHP has contributed $100,000 for the design and development, joining a large number of medical organizations. The donation was made on behalf of the parent-organizations of the SAHP, and should preserve the appropriate place of Otolaryngology-Head and Neck Surgery in materials promulgated to the public, on either rhinosinusitis or allergic rhinitis, by the National Health Museum.

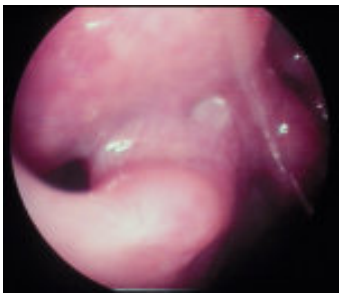
The Sinus and Allergy Health Partnership (Drs. M. Benninger, I. Emanuel, J. Hadley, D. Kennedy, D. Lanza, D. Osguthorpe, and J. Stankiewicz) wishes to thank our parent organizations, and the members they represent, for the continuing support of our educational and research endeavors. Please direct your questions and/or suggestions for the SAHP to either the parent organizations or the SAHP via its Executive Director, Jami Lucas, or Coordinator, Willis Shawver, at 1990 M Street, NW, Suite 680, Washington, DC 20036 (Phone: (202) 955-5010, ext 104; FAX (202) 955-5016; e-mail: sahp@sahp.org).

POINT...

MINIMALLY INVASIVE SINUS TECHNIQUES: MIST A SURGICAL MODEL FOR THE TREATMENT OF CHRONIC SINUSITIS

PETER CATALANO, MD, FARS

MIST, for the treatment of chronic sinusitis, has become increasingly popular since its introduction in 1996. This surgical model is the true embodiment of *functional* concepts originally described by Messerklinger between 1968-1978. Application of the "functional theory", originally termed FESS, was based on *conservatism*, with surgical intervention limited to the sinus transition spaces (i.e. ethmoidal infundibulum, hiatus semilumaris superior, and retroagger space). The goal - "to re-establish ventilation and drainage of the dependent larger sinuses through their natural ostia, usually without touching the larger sinuses themselves" (1). Pathologic mucosal change, even when "massive", was considered reversible in all cases (1). The definition of what constitutes irreversible mucosal disease after re-establishing normal sinus drainage and ventilation remains elusive and controversial (2). The foundation statements of Messerklinger's functional concepts are indistinguishable from those of MIST. Thus, the MIST surgical model applies a literal translation of this philosophy.



Natural ostium of the right maxillary sinus

MIST, in it's simplest form, is a targeted intervention, or 'threshold' surgical procedure. It is much more than *not* performing a middle meatal antrostomy. The MIST philosophy, based on tissue preservation and transition space surgery, has established the only intranasal procedure based on a stepwise, anatomic progression of surgery that has a defined beginning and end. Other forms of conventional endoscopic sinus surgery are far less disciplined, often allowing the surgeon excessive freedoms within the nasal cavity. Turbinates may or may not be resected, middle meatal antrostomies (MMA) may or may not be performed. The uncertainties and possibilities are numerous. If a patient tells us he/she had a parotidectomy, we have confidence in what was done; if they claim to have had sinus surgery, we can only guess. However, if a patient states they had a MIST procedure, we know exactly what surgery was performed. The MIST surgical model standardizes the procedure for surgeons and patients alike. Although the majority of the dissection is performed with powered instrumentation, a few pediatric hand instruments are needed. The former provides real time suction for better visualization, and true cutting blades to preserve birth membranes.

The advantages of MIST are numerous. Because the surgery is based on conservatism and mucosal preservation, potential for scarring within the nasal cavity is minimized, and iatrogenic sinusitis, especially of the frontal sinuses, is rare. Problems/revisions related to creation of a MMA are eliminated. Operative time and intra-operative bleeding are reduced, obviating the need for postoperative nasal packing. Because the healing burden placed on the nasal cavity is limited, overall peri-operative patient morbidity is reduced allowing most patients to return to work or school within 24-48 hours after surgery.

Recent outcome studies at 24 months post-MIST have shown significant clinical improvement across the spectrum of disease severity, with revision rates following MIST under 6% (3). These studies show that patient outcome following MIST is *at least* equal to those of other endoscopic intranasal procedures. These findings, coupled with the numerous other advantages offered by MIST, support the consideration of MIST as the *initial* procedure for patients undergoing endoscopic sinus surgery for chronic sinusitis.

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IN PREPARATION FOR THE 50TH ANNIVERSARY CELEBRATION OF THE AMERICAN RHINOLOGIC SOCIETY, WE PRESENT OUR NEW LOGO:

ARS American Rhinologic Society 50TH ANNIVERSARY

1954-2004

Fifty Years of Rhinology

...of View

Functional Endoscopic Sinus Surgery: FESS

David W. Kennedy, MD, FARS

Proponents of minimally invasive sinus surgery (MIST) proselytize that they are ones who are performing the true functional techniques envisioned by Messerklinger, because what they are doing is providing drainage of the sinuses with a minimal mucosal preserving procedure. Indeed they claim just to have further improved upon an already good technique. Unfortunately, (or fortunately) our knowledge of the pathogenesis of chronic rhinosinusitis has progressed since the early days of Messerklinger.[1] We have increasingly identified and demonstrated that chronic rhinosinusitis is not merely an issue of plumbing and of providing appropriate drainage. [2] We have learned that the adjacent bone becomes actively involved in the disease process and that, at least in an animal model, this inflammation can spread widely through the Haversian canals within the bone.[3] Thus it becomes unlikely that just creating an opening, leaving the bone in place, is really sufficient. We have also learned that if you leave bony partitions during a surgical procedure and inflammation continues, the bone then this residual bone becomes thickened over time. Thus it becomes dramatically more difficult to remove this bone at a later time without causing significant mucosal trauma. Proponents of MIST will also argue that the results of MIST are similar to those of more extensive surgery. However, these are subjective results of combined surgery and medical therapy, and subjective results are uniformly good with all endoscopic sinus surgery techniques. Moreover, as we know, early postoperative subjective improvement does not necessarily translate into resolution of disease.[4] Indeed, persistent asymptomatic disease frequently continues and may take many years to again become symptomatic.

MIST certainly has advantages in that it provides rapid healing and good mucosal preservation. For children who have not had longstanding problems it is probably an appropriate approach. Similarly in very minor disease in adults it may have a role. However, most adults with such minor disease are probably better treated with medical therapy directed at the underlying causes of the disorder rather than with a surgical intervention, for we now know that anatomic issues are not the most significant factor in the pathogenesis of chronic rhinosinusitis. Persistent mucosal inflammation is a major issue and in more extensive and longstanding chronic rhinosinusitis the bone clearly becomes involved, frequently devitalized and may present a pathway for the spread of the inflammation.[3,5] Accordingly, it makes sense to completely remove these bony partitions within the area involved in the disease process while, at the same time, carefully preserving the mucosa on the surrounding bone that cannot be removed. This is not an easy task and it takes more time, making technically more difficult and less remunerative to the surgeon than MIST. However, given our current knowledge of the disease process, complete removal of the bony partitions within the region of disease is the approach that makes sense, and it is also the approach that has demonstrated both subjectively *and objectively*, excellent results over a true long term follow up period, when combined with appropriate medical management.

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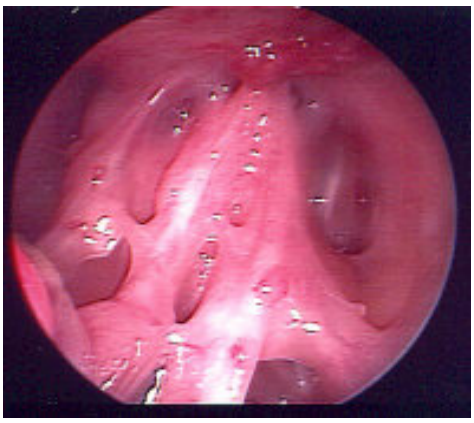
Case of the Quarter
Endoscopic Modified Lothrop

Stilianos Kountakis, MD, FARS

Frontal sinusitis and the extent of surgery performed in the frontal recess once medical management fails, is constantly debated in the literature. Despite significant advancement of endoscopic instrumentation, frontal sinus surgery remains challenging because of the complex anatomy of the frontal recess and the proximity of important structures such as the skull base and lamina papyracea.

Open non-preservation and obliterative surgical techniques were popularized by Montgomery et al in the 1960s.[1,2] These techniques became the gold standard since they avoided the complex anatomy of the intranasal frontal recess approach and thus, they minimized complications involving important frontal recess proximal structures. Recent reports however revealed frontal mucoceles on MRI in 9.4% of the patients an average of 2 years after frontal sinus obliteration.[3] In addition, in my practice, I have seen patients with frontal mucoceles requiring revision at least 20 years after frontal sinus obliteration.

The endoscopic modified Lothrop procedure preserves mucosa and involves removal of both frontal sinus floors with a septectomy to create a large common nasofrontal pathway. Success of this surgery depends on the patient's anatomy and underlying mucosal disease.[4] Poor outcomes can be encountered in patients with small frontal sinuses and sinuses with an anterior-posterior dimension of less than 1.5 cm at the level of the cephalad margin of the frontal recess. In addition, patients with mucosal diseases such as allergic hyperplastic sinusitis, sarcoidosis and Wegener's granulomatosis should be expected to have persistent postoperative mucosal inflammation unless the underlying disease is medically controlled.

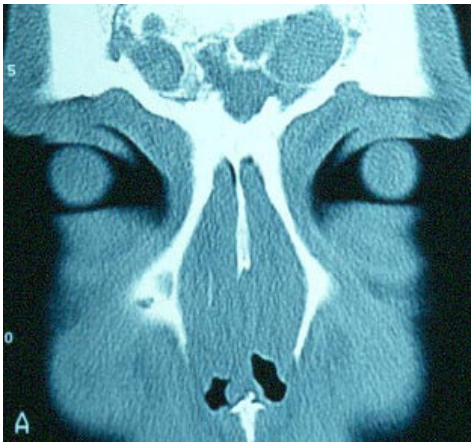


The endoscopic modified Lothrop procedure begins with identification of the frontal recess and frontal ostium of one side. Drilling is then initiated in an anterior direction through the anterior insertion of the middle turbinate until the level of the nasal bones is reached. The direction of drilling then changes medially, part of the nasal beak is removed, and the nasal septum is approached. A septectomy is then performed and then drilling continues toward the opposite side removing the remnant of the nasal beak and continues until the opposite lamina papyracea is reached. Care is taken to preserve the mucosa at the posterior margin of the frontal recess to prevent circumferential scarring.

Post-operatively, endoscopic debridements are performed in the office until all debris is removed. In addition, medical management is maximized to ensure mucosal healing.[4] We recently published our long-term results with this technique and reviewed the literature.[5] The overall success rate was 82% and if patients failed, they seem to do so at approximately 18 months after surgery. If patients treated with the Lothrop procedure ultimately require frontal sinus obliteration, the obliteration can be easily performed using a pericranial flap to reconstruct the missing frontal sinus floors. Thus I recommend that the endoscopic modified Lothrop procedure should be attempted, if possible, prior to considering frontal sinus obliteration.

Case report

A patient who benefited from the modified Lothrop procedure was a male in his late twenties who suffered from nasal obstruction, congestion, pressure, and pain. He had frequent post-nasal drip and thick drainage despite maximal medical therapy. His endoscopic exam revealed extensive nasal polyposis with obstruction and copious nasal secretions.



Initially, he underwent functional endoscopic sinus surgery with nasal polypectomy. Despite a good response to the surgery with control of disease in his maxillary and ethmoid sinuses, he had persistent mucosal disease in his frontal sinuses with polypoid tissue in his frontal recesses. These findings are demonstrated in the CT scan image.

The patient then underwent endoscopic modified Lothrop surgery to address this frontal sinus disease. Mucocilliary clearance was preserved by minimizing injury to the mucosa of the lateral frontal recess. Circumferential scarring was avoided by preserving the mucosa of the posterior wall of the frontal sinus at the level of the frontal ostium. The endoscopic photograph illustrates the paired ostia leading into the right and left frontal sinuses in this patient six months after surgery.

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Information Technology

Martin Citardi, MD, FARS
Information Technology Officer

In December, 2002, the ARS launched ARS Member Services, a web-based application that serves a web portal for customized content for all ARS members. Through ARS Member Services, an ARS member may pay his or her dues via the Internet, and update the contact information in his or her member profile. Although these are important new services for the ARS membership, the web programming that supports ARS Member Services also provides infrastructure for a wide variety of enhancements that will be deployed over the next 1-2 years.

Many members are familiar with the public web pages at www.american-rhinologic.org, but most members are not familiar with the critical ARS functions that have been moved to an Internet-based model since 1999. Wildfire Internet Services (www.wildfireinternet.com) has developed a customized application for the management of the ARS membership database. The application and the data reside on Wildfire's servers; access is provided through the Internet. The system is designed to provide a global platform for the integration of all ARS organizational functions, including dues, meeting registration, abstracts, etc. This system assigns each member a customized web profile that determines what the member sees when he or she accesses the system. By default, all members have access to dues payment and contact information updates; however, other features may be added to a member's profile. For instance, a member who serves on the abstract review committee also access those abstracts through the same web interface. The result is that each member has a web experience that has been customized for his or her needs.

The new system has been used for the 2003 dues cycle. Briefly, the new dues process involves the following steps:

The ARS Board of Directors sets the dues amounts for each membership category.

- The ARS administrator enters dues rates for each membership category into the system.
- The new application generates a dues invoice for each member. The invoice is sent to each member by E-mail, fax, or regular mail.
- ARS members who wish to pay their dues via the Internet must log into the system (outlined below) and follow the instructions for the transaction. ARS members may also forward credit card info by fax or regular mail, or they can forward a check. The ARS administrator must manually enter these transactions into the system.

To log in to your Member Services Area, go to http://app.american-rhinologic.org/controller.jsp?ACTION=HomePage and select the Member Sign In button.

It should be noted that the ARS Board of Directors has approved a 10% discount for all payments processed through the Internet. All ARS members are encouraged to use the Internet-based system for the fastest service. The new system will also reduce costs associated with the administration of the society's functions—so that members get more value for their dues dollars.

Credit card transactions processed through the site are considered secure, since the system has been designed in accordance with the standard provisions of Internet-based e-commerce. If members are uncomfortable with the new system, they can still pay in the traditional ways, but will not receive the 10% discount.

Early feedback about ARS Member Services has been quite positive, but there have been a several problems. A few members had misplaced their user names and passwords. Internet traffic can slow the display of web pages, and old browser software may cause other problems. All members are encouraged to use an up-to-date Internet browser with 128-bit encryption. Microsoft Explorer (version 5.5 or later, with 128-bit encryption) is preferred. If you experience a problem, please forward all relevant info (including your browser type and version as well as an explicit description of error message) to the ARS IT Committee (E-mail: arsinfo@american-rhinologic.org; fax: 216-274-9753).

To access ARS Member Services, please go to:
http://app.american-rhinologic.org/controller.jsp?ACTION=HomePage
(You an also click on the key icon in the header at the top of each public ARS web page.) You will need your user name and password. (User names and passwords were distributed in December. If you need a reminder, please send a brief message to arsinfo@american-rhinologic.org.)

Questions and comments can be directed to arsinfo@american-rhinologic.org.

To review your member profile and pay your annual dues, select the My Member Profile button on this page. You can also access the e-Abstract module and register for ARS meetings and events from this page. Note that this page is password-protected.

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Upcoming Rhinology Meetings and Courses

Endoscopic Frontal Sinus Surgery and Endoscopic Revision Sinus Surgery		April 3-4, 2003
Vanderbilt University	Contact: 615-322-4030	
Advanced Functional Endoscopic Sinus Surgery		April 3-5, 2003
Georgia Nasal and Sinus Institute	Contact: 912-350-3655	
UCSF Advanced Endoscopic Sinus Surgery Dissection Course		April 10-12, 2003
UCSF	Contact: 415-476-4251	
The Carolina Course in Sinus Surgery and Facial Plastic Surgery		April 11-12, 2003
University of North Carolina	Contact: Elizabeth 919-966-8926	
NY Rhinology and Sleep Disordered Breathing Update		April 11-13, 2003
NYU and Albert Einstein	Contact: Kathy Granger 212-263-5294	
Advanced Endoscopic Sinus Surgery Course		June 12-13, 2003
Medical College of Wisconsin	Contact: Diann 414-805-5609	
Advances in Endscopic Management of Nasal and Sinus Disorders		November 6-8, 2003
Cleveland Clinic Foundation	Contact: Anne Monreal 216-444-4949	

If you would like to have your upcoming rhinology meeting noted here, simply provide the editor with pertinent information: newsletter@american-rhnologic.org

The American Rhinologic Society does not endorse these meetings but simply provides this list as a service to its members

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