

Summer Sinus Symposium 2013 - Just Around the Corner!

Kevin C. Welch, MD, Rakesh Chandra, MD, James N. Palmer, MD

The Second Annual ARS Summer Sinus Symposium is taking place July 19-20, 2013 in Chicago, IL at the Westin Michigan Avenue. Once again, this Symposium promises to be an exciting, highly educational program that brings together interested otolaryngologists in one forum to discuss the latest aspects of rhinology, facial plastic surgery, reflux disease and obstructive sleep apnea.

On the first day, Dr. David Kennedy will kick off the event with a keynote address, and this will be followed by panels and discussions, which feature the most seasoned experts discussing common situations and how to manage even the most challenging

patients. Demonstration dissections performed by Dr. Donald Lanza and Dr. Michael Sillers will help surgeons refine their techniques in both conventional sinus surgery as well as balloon dilation procedures. Audience interaction will be maximized to facilitate discussion with the panelists. After an education-packed first day, join us on the 95th floor of the John Hancock Tower to dine at the Signature Room and enjoy a fabulous skyline nighttime view of Chicago.

The second day will include a mixture of combined and breakout sessions where attendees can select from a variety of subspecialty topics such as the practice of allergy, rhinoplasty,

pediatric rhinology, practice management and several excellent panels featuring video and advice from the experts on "how they do it."

Please come enjoy the fellowship of your Otolaryngology colleagues in one of America's great cities. Chicago has many engaging tourist attractions, as well as opportunities for shopping, dining, theater, and professional sports.

Participating physicians will have the opportunity to earn up to 16.75 AMA PRA Category 1 credits™. For details, please visit www.american-rhinologic.org/ars_courses.

SAVE THE DATES:
JULY 19-20, 2013
 CHICAGO, IL • WESTIN MICHIGAN AVENUE

2013 ARS SUMMER SINUS SYMPOSIUM

David Kennedy, MD (Keynote Speaker), Don Lanza, MD
 Michael Sillers, MD, Peter Hwang, MD, Tim Smith, MD
 James Stankiewicz, MD, and many, many more...

COURSE DIRECTORS:
 Rakesh Chandra, MD, James Palmer, MD, Kevin Welch, MD

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The American Rhinologic Society would like to thank Acclarent, Entellus, Olympus/Gyrus, SinuScience and Xoran for partnering with the ARS Newsletter for 2013.

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Tim L. Smith, MD

Save the Date! Sept 28, 2013 ARS at AAO-HNS, Vancouver, BC

Tim L. Smith, MD, President Elect and Program Chair

Reasons you cannot miss The ARS at AAO-HNS!

- **Panel:** *What is Happening in the World of Rhinology: An International Forum of Allergy & Rhinology*
- **Insightful Discussions:** *In hindsight, I would have handled this differently. Lessons learned the hard way...*
- **ARS/AAOA Combined Panel:** *Changing Your Practice: Strategies to Manage Your Patients with Recalcitrant Rhinosinusitis*
- **The 9th Annual Kennedy Lecture: Berrylin J. Ferguson, MD: Twenty-five Years of Sinus Study: Learning and Unlearning**
- **Showcasing ARS Research and the International Forum of Allergy and Rhinology**

Join your colleagues to discuss the latest advances in our field and discuss your challenging cases!

Explore the exhibits of our Industry Partners where the latest technology is unveiled!

For additional details, visit www.american-rhinologic.org/annual_meeting

2013 Dates

SUMMER SINUS SYMPOSIUM

July 19-20, 2013

Westin Michigan Avenue,
Chicago, IL

59TH ANNUAL MEETING

September 28, 2013

Hyatt Regency Vancouver,
Vancouver, CAN

ARS Calendar of Events

www.american-rhinologic.org/calendar_events



Vancouver, BC



Todd Kingdom, MD

President's Report

Todd Kingdom, MD

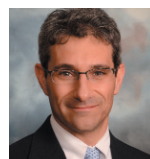
Summer is upon us, and I sincerely hope you are able to enjoy this time with friends, family, and loved ones. Our meeting at COSM in Orlando was an enormous success on all fronts. I want to thank Program Chairman Tim Smith and his committee for once again pulling together a wonderful program that included broad and relevant content. The next major event for the ARS on the calendar is the Summer Sinus Symposium in Chicago on July 19-20. Phenomenal efforts have come from our course directors Rick Chandra and Kevin Welch to make this a success. Additional information about this great summer program is contained in this newsletter. Then, moving on to the fall, we have our Annual Meeting in Vancouver on September 28. Program Chairman Tim Smith will again work his magic to deliver a scientific program that will provide a tremendous breadth of clinical, research, and translational content for our members.

I would like to share a few comments from our Board of Directors meeting held in Orlando during COSM. The energy from our committee chairs and Board leadership continues to be remarkable. The appetite to take on new initiatives and explore different opportunities has never been greater. With this comes challenges that we must meet head on. Much of the conversation centered around our growing educational and training programs, the need to restructure and define our strategic initiatives in marketing and communications, and our desire to expand our commitment to research funding.

Sustainable funding for our research efforts is a priority for the Board and me. The "Friends in Research" campaign for donations directed to research was launched in 2010 with early initial success. I feel we can, and must, do better as a group. I have asked Board member Rob Kern to help me re-focus this important effort. I have challenged the Board of Directors and our committee chairs

with 100% participation over the course of the next 12-18 months. I hope the all ARS members will participate at some level and help solidify our ability to remain the premier organization funding rhinologic research. Plans are underway to revamp the on-line donation process, but you may visit <http://www.american-rhinologic.org/donate> to give today. Additional information and communications will be forthcoming as we roll out this important initiative.

I will close with thanking our corporate partners that continue to provide tremendous support to our missions of research, training and education, and advocacy. Their initial response to our efforts to strengthen this partnership has been overwhelmingly positive and a source of validation for what the Board is trying to achieve. I send out my sincere gratitude to the numerous corporate partners that have stepped forth to work with us as we move forward.



Noam Cohen, MD

Research Committee Update

Noam Cohen, MD, PhD

Once again, Rhinologic research demonstrated substantial interest, as reflected in the number of grant submission reviewed at the 2013 CORE Study Section review. The ARS received 16 proposals, one of the strongest showings for a sister society and slightly more than we received last year. This year we had one proposal in the New Investigator mechanism and two proposals in the Resident Grant mechanism that were worthy of funding and I would like to congratulate this years ARS grant recipients:

ARS Young Investigator

Nithin Adappa, MD
(University of Pennsylvania)
"T2R38 Polymorphisms as a Disease Modifier of CF Chronic Rhinosinusitis"

ARS Resident Research Award

Adam Kimple, MD, PhD
(University of North Carolina)
"Regulator of G-Protein Signaling-22: a Putative Regulator of Motile Cilia"

Sarah Novis, MD

(University of Michigan)
"Variations in Antibiotic Usage for the Treatment of Acute Sinusitis"

These awards will be officially acknowledged at the AAO-HNS Annual meeting in Vancouver on October 1st at 10:30 - hope to see you all there supporting our young Rhinologic researchers.

I would also like to extend my thanks and acknowledge the ARS members who spent substantial time and effort in reviewing the grants and serving on the CORE Study Section (Andrew Lane, Brad Woodworth, Eric Holbrook, Sarah Wise, Bruce Tan, Rod Schlosser, Ben Bleier, Murray Ramanathan, Vijay Ramakrishnan, Adam Zanation, Zach Soler, Eric Wang, Jay Pinto). We hope to maintain this strong interest in Rhinologic research and see even more applications next year.



Seth M. Brown, MD

Patient Advocacy Committee (PAC) Corner: *Proper Coding of Frontal Sinus Surgery in 2013*

Seth M. Brown, MD, MBA, FACS, PAC Chair

One question I am often asked is how to properly code frontal sinus surgery. This has become more complex through the years as there are times where more than one approach is used for a frontal sinus (i.e. endoscopic assisted surgery), or for a more extensive opening (i.e. frontal sinus drillout).

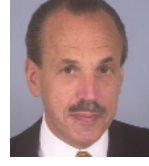
Furthermore, in 2012 we saw the emergence of new codes for balloon sinuplasty. The following sums up what should be done.

1. Every endoscopic code is a unilateral code (you may add a 50 modifier to these codes).
2. You may only use 1 code per sinus (i.e. you cannot bill an open code and an endoscopic code on the same sinus).
3. Understand that open codes fit into a 90 day global period and thus postoperative care, serial endoscopies and debridements are included in the code.

The most common frontal sinus codes and situations are explained as follows:

1. 31296 - when a balloon is used to open a frontal sinus and no additional dissection or tissue removal is done.
2. 31276 - standard endoscopic frontal sinus code - for cannulation of the ostium and tissue removal.
3. Frontal sinus drill-out. No code exists. Options are to use 31276-50, 22 (plus image-guidance if used) or utilize the unlisted code 31299 and chose a comparison code when applying to the payor (I use an anterior skull base approach code). I prefer the unlisted code as I do not feel 31276 adequately describes the time, effort, risk and equipment required to perform this procedure.
4. Endoscopic assisted frontal sinusotomy (i.e. trephine and endoscopic) I use the endoscopic code 31276 and add the 22 modifier (more complex than). This allows me a zero day global period and more appropriately describes that the main procedure was from below but the trephine was used for access (often used for a lateral cell).

Please feel free to contact the ARS for individual coding questions or concerns.



Joe Jacobs, MD

Treasurer's Report

Joe Jacobs, MD

The ARS, under the active leadership of Todd Kingdom and the Board, has undertaken a major revamping of our fundraising process. Since our 50th Anniversary Meeting, we have provided space for exhibitors, and our society has continued to knock on the door of our corporate partners to help support our educational, advocacy, and scientific programs. The ARS cannot expand and serve our membership without these corporate relationships. Over time, as our programmatic aspirations have increased, we recognized that a more secure and directed fundraising effort is required. Our administrator Wendi Perez has always handled this responsibility in addition to her other numerous roles and jobs.

In order to solidify and extend this process we have established a Development Committee composed of senior members of the society. In addition, we have enlisted the support of an additional staff member, Susan Arias, whose only responsibility will be to establish and nurture corporate relationships. Our goal is to raise increasing amounts of funding to provide our membership with the underlying support that they deserve. This is a time consuming as well as a grinding process, but we have been highly successful in the initial 6 months and expect to raise over \$500,000 to fund active society programs. I know that we will see the benefits of our program shortly.

Secondly, under the sound management of Mellon Bank our reserves are secure and are growing due to the positive movement of the financial markets in the last few years. However, due to our increasing expenses we still depend on fundraising to avoid a loss of the corpus. So far, we are capable of doing so. In addition, in order to avoid a significant deficit I have been working with Shu Das, Chairman of the Audit Committee, to secure this process. His report follows.

The Audit Committee of the ARS serves to assist the Board of Directors in maintaining the overall integrity, financial credibility, and long-term viability of our non-profit organization. In this role, we serve as an independent committee that reviews the governance of our organization to mitigate risk and ensure compliance with increasing federal, state, and local laws and regulations facing the ARS and its membership; we assess business risk and provide recommendations to mitigate this risk, monitor our financials, ensure internal and external audits of our financials are performed on a timely and independent basis, review our tax filings, and along with our Ethics committee, review our organization's conflict-of-interest, code-of-ethics, and whistleblower policies. Currently, the ARS is transitioning to a new financial accountant; however, the audit committee has maintained an unqualified opinion without significant reservation in respect of matters contained within the ARS financial statements for several years.

For upcoming course
information, visit:

www.american-rhinologic.org/ars_courses

Case of the Quarter: Sinonasal Sarcoidosis

Jonathan Liang, MD and Douglas Reh, MD

A 39-year-old African American woman with a history of chronic rhinosinusitis was referred for tertiary management of her chronic recalcitrant symptoms and consideration of revision sinus surgery. She complained of bilateral nasal congestion, post-nasal drip, decreased sense of smell, and facial pressure. She underwent endoscopic sinus surgery 4 years ago, but her symptoms recurred a few months later and have been worsening over the last 2 years. She has been treated with antibiotics for symptom exacerbation. She has been using nasal saline irrigation and steroid sprays. She is otherwise healthy except for a history of skin lesions. Endoscopic examination revealed severe sinonasal inflammation, adhesions and scar tissue at prior surgical sites, friable edematous mucosa (Figure 1) and submucosal nodules (Figures 2). CT demonstrated mucosal thickening and pansinus opacification (Figure 3), while chest X-ray was normal. Laboratory evaluation revealed an ESR of 40 mm/hr (normal 0-25 mm/hr), serum calcium level of 10.0 mg/dL (normal 9.0-10.5 mg/dL), ACE level of 45 mg/L (normal <40 mg/L), negative C-ANCA and P-ANCA, negative RF, and negative ANA. A biopsy of the submucosal nodule was performed. Histopathology demonstrated non-caseating granulomas, confirming a diagnosis of sinonasal sarcoidosis (Figure 4).

Sarcoidosis is a systemic granulomatous disease of unknown etiology. The annual incidence is estimated between 6 to 20 in 100,000.¹ This disease usually presents in the 3rd to 5th decade of life, and is more common in females and patients of African-American descent. Sarcoidosis can involve multiple systems, with pulmonary involvement being the most common.² Sinonasal sarcoidosis occurs in approximately 1% of patients, but this may be an underestimation.³ Patients with sinonasal sarcoidosis usually have other organ system involvement, but up to 10% occurs in the absence of any pulmonary disease.³ Sinonasal involvement may represent a severe and recalcitrant form of sarcoidosis, with one study demonstrating a significantly increased incidence of organ involvement and need for systemic therapy compared to sarcoidosis patients without sinonasal involvement.⁴

Clinical suspicion for sarcoidosis is paramount for early diagnosis. Sarcoid rhinosinusitis can be confused with chronic rhinosinusitis or other granulomatous diseases (Wegener's granulomatosis, Churg-Strauss syndrome, tuberculosis, aspergillosis, actinomycosis). Delayed diagnosis can lead to chronic symptoms, mucosal damage and scar tissue, nasal septal perforation, atrophic rhinitis, and unnecessary sinus surgery. Symptoms include nasal

obstruction, congestion, crusting, epistaxis, post-nasal drip, recurrent episodes of sinusitis, hyposmia or anosmia, facial pain, and headache. A case control study found that nasal crusting, anosmia, and epistaxis were the most specific indicators for sarcoid rhinosinusitis.⁵ Endoscopic examination can demonstrate friable edematous mucosa, crusting, mucosal cobblestoning, and yellow submucosal nodularities.³ Commonly affected areas are the septum and inferior turbinates.⁶ Other findings include nasal polyps and septal perforation. Intracranial, skull base, and nasolacrimal involvement are very rare.⁷⁻⁸

A diagnosis of sarcoidosis is confirmed by biopsy demonstrating non-caseating epithelial cell granulomas. Directed biopsies of abnormal mucosa or atypical lesions such as nodules have significantly greater yield than blind biopsies.⁹ Radiographic imaging may demonstrate opacification of the paranasal sinuses, similar to chronic rhinosinusitis. Chest X-ray may show hilar adenopathy. Laboratory findings are non-specific but may reveal elevated serum and urine calcium levels, and elevated serum ACE level.

The mainstay management of sinonasal sarcoidosis is systemic medical therapy with corticosteroids. Nasal saline irrigation, topical corticosteroid sprays, steroid irrigation, and intra-lesional steroid injections have been suggested for treating sinonasal symptoms with variable success. The role of surgical therapy for sarcoid rhinosinusitis is controversial. Nasal endoscopy with biopsy is helpful in establishing a diagnosis. The role of function endoscopic sinus surgery (FESS) as the main treatment modality is very limited given the recurrent and refractory nature of the disease.¹⁰ Surgery is contraindicated in patients with active disease and severe sinonasal mucosal inflammation as this may contribute to increased scar tissue formation. Select patients whose disease is quiescent and have significant anatomic blockage due to prior scar tissue formation may benefit from surgery. FESS has been shown to relieve symptoms, reduce steroid dependency, and improve quality of life in the short-term in select patients.¹⁰⁻¹¹ One rationale for FESS is to allow for in-office endoscopic debridement and improved application of topical medications. Chronic rhinosinusitis due to an underlying systemic disorder such as sarcoidosis can

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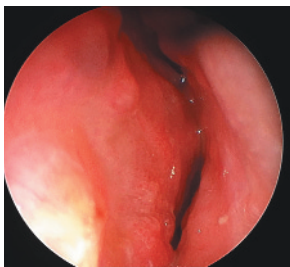


Fig 1 Nasal endoscopy demonstrating friable inflamed mucosa and cobblestoning pattern.

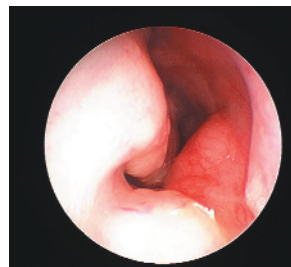


Fig 2b Nasal endoscopy demonstrating yellow-colored submucosal nodule.



Fig 3 CT demonstrating pansinusitis similar to chronic rhinosinusitis

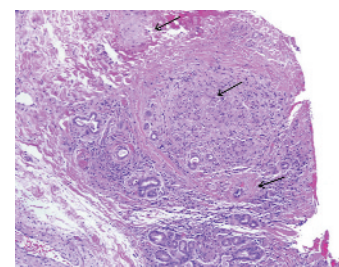


Fig 4 Histology (H&E, high power) demonstrating non-caseating granulomas (arrows) in sinonasal tissue.

Rhinology Perspectives: *Topical Therapies in the Treatment of Chronic Rhinosinusitis*

Jivianne Lee, MD and Alex Chiu, MD

Topical therapies have emerged as an integral component in the comprehensive management of chronic rhinosinusitis (CRS). Such targeted application affords the theoretical advantage of delivering high concentrations of therapeutic agents directly to diseased sinonasal mucosa while reducing the risk of systemic absorption and associated adverse effects. Because irrigant penetration into unoperated sinuses is minimal (<2%), endoscopic sinus surgery (ESS) is pivotal in providing effective sinonasal distribution of topical solutions. Currently, otolaryngologists are confronted with a myriad of topical preparations available for CRS. We will briefly summarize these various treatment strategies and the accompanying evidence for each regimen.

TOPICAL SALINE: The benefits of topical saline irrigations in the treatment of CRS have been well documented. In a Cochrane review of 8 randomized control trials (RCTs), Harvey, et al. determined that saline irrigations improved both CRS symptoms and quality-of-life (QOL) when used as the sole treatment modality and as adjunctive therapy (Harvey 2007). However, whether isotonic or hypertonic saline (HS) is more effective still remains controversial. Hypertonic solutions have been shown to reduce symptoms in patients with cystic fibrosis (CF) and asthma, but have also been associated with impaired ciliary activity as well as local adverse effects (i.e. nasal irrigation, burning, pain). No significant differences were identified between isotonic versus (vs.) HS in terms of symptom, nasal endoscopic (NE), or radiographic scores in the Cochrane review. Thus, although saline irrigations are currently indicated in the management of CRS; definitive recommendations regarding optimal concentration, frequency, and mode of delivery cannot be made at this time.

TOPICAL STEROIDS: The clinical efficacy of intranasal steroids (INS) in the treatment of CRS is well-established; and their use as first-line therapy has been recommended by multiple evidence-based studies. (Fokkens 2012, Rudmik 2012). Administration of off-label topical steroid preparations (i.e. budesonide 0.5mg/2ml in 240ml saline) has also become increasingly more common as a promis-

ing alternative to systemic steroids in the post-operative management of CRS. In a recent prospective uncontrolled study, post-ESS steroid irrigations (budesonide 1mg or betamethasone 1mg, 240ml saline) led to significantly improved symptom, QOL, and NE scores in 111 CRS patients (Snidvongs 2013). Such steroid solutions have been shown to be well tolerated in the short-term, with no evidence of hypothalamic-pituitary-adrenal axis suppression as measured by changes in serum or 24-hour urinary cortisol. However, no RCTs have demonstrated their superiority over INS or saline rinses. In a double-blinded (DB) RCT of 60 Samter's CRS patients randomized to saline lavages (240ml), budesonide spray (64ug per nostril twice daily), or budesonide saline irrigations; no significant differences in symptom, NE, or imaging scores were observed 6 months and 1 year after treatment (Rotenberg 2011). Consequently, steroid delivery via irrigation modalities still warrants further investigation to determine clinical efficacy as well as the safety of long-term use.

TOPICAL ANTIFUNGALS: Since fungus was first postulated to contribute to the pathogenesis of CRS, extensive research has been conducted assessing the effectiveness of topical antifungal therapies. In the initial pilot study, intranasal amphotericin lavages appeared to successfully reduce mucosal inflammation in CRS on both imaging and NE after 6 months (Ponikau 2005). However, these results have not been replicated in subsequent trials. Four DB-RCTs involving much larger patient cohorts failed to demonstrate any significant differences in subjective (symptom, QOL) or objective (NE, imaging) outcomes between CRS patients treated with topical amphotericin vs. placebo (Ebbens 2006, Weschta 2006, Liang 2008, Gerlinger 2009). In addition, 2 recent meta-analyses independently concluded that topical antifungals were not beneficial in the management of CRS based on a review of the aggregate evidence (Isaacs 2011, Sacks 2011). Consequently, topical antifungal therapy is not currently recommended in the treatment of routine CRS.

TOPICAL ANTIBIOTICS: Thus far, the use of topical antibiotics in CRS has only been supported by low-level studies.

Optimal outcomes are achieved in post-surgical patients given culture-directed as opposed to empiric therapy (Lim 2008). Administration of topical antibiotics via nebulizer or spray techniques have failed to demonstrate significant clinical benefits and their use has not been recommended (Rudmik 2012). However, topical antibiotics delivered via irrigation methods have shown promise in the treatment of refractory CRS. Tobramycin lavages have been reported to decrease nasal polyposis and the need for revision surgery in CF patients with *Pseudomonas aeruginosa* (PA) positive recalcitrant CRS (Moss 1995). Likewise, mupirocin irrigations have been found to significantly improve symptoms, NE scores, and culture rates in *Staphylococcus aureus* (SA) positive refractory CRS (Solares 2006, Uren 2008, Jervis-Bardy 2012). However, a 73.7% re-culture positivity rate has also been observed following therapy, so it is unclear if such benefits are sustainable long-term. Additional research is still required to elucidate the clinical implications of microbiological relapse, risk of systemic toxicity, and development of antibiotic resistance associated with prolonged use. Therefore, topical antibiotics are not recommended as first-line therapy for routine CRS, but can be considered as a potential option for patients with recalcitrant CRS who have failed traditional medical and surgical intervention.

TOPICAL ADDITIVES: A vast array of alternative agents with antimicrobial, anti-inflammatory, and immunomodulatory properties have been introduced as potential additives to irrigation solutions. Manuka honey (MH) exhibits microbicidal activity against SA/PA biofilms in vitro, and symptomatic improvement in CRS patients has been reported with topical application of MH mixtures (Thamboo 2011). Likewise, dead sea salt rinses, which contain unique minerals with anti-inflammatory effects, have been shown to improve symptoms and QOL in CRS patients (Friedman 2012). Xylitol, an organic sugar alcohol which enhances the potency of endogenous antimicrobial factors, was also observed to significantly decrease symptom scores in post-ESS CRS patients compared to saline (Brown 2004). Finally, surfactants have potentially dual benefits in the treatment of CRS, acting as both a mucolytic agent as well



David Kennedy, MD

International Forum of Allergy and Rhinology (IFAR) Update

David W. Kennedy, MD, IFAR Editor

The *International Forum of Allergy and Rhinology* (IFAR) began monthly publication in January 2013, becoming the only specialty journal within the field of Rhinology with 12 editions each year. This allows the Journal to decrease the time for authors from article submission to print publication. The Journal has also previously been accepted for Medline and ISI Impact Factor rating. Both of these extend back to the first edition of the Journal. Although the initial Impact Factor is anticipated to be low, this will rapidly change. The Impact Factor is based upon the average number of citations and new journals do not have a significant track record of cited articles. Additionally, the calculations are based upon an annual rolling average. However, the Editorial Board, the societies (ARS, AAOA, IRS and ISIAN) and the publishers (Wiley) are all committed to ensuring that this becomes a leading journal within the broader specialty. Accordingly, the Impact Factor will rapidly grow, and as the Impact Factor of the Journal continues to grow, additional prestige will be added for authors who submit or who have already published in IFAR. The goal of the involved societies

is to ensure that IFAR is the premiere journal in the field internationally, as well as developing online Journal educational content for the societies. In each print edition, we try to keep a balance between basic research and clinical papers, and thus, the time to print publication for more basic research tends to be shorter than for clinically related papers.

Even prior to print publication, articles are published online and the online publications are indexed in PubMed prior to print publication. In 2012 there were 35,681 IFAR articles downloaded from the Journal website. Wiley, as is customary when new journals have matured, started charging institutions for online access in January 2013. I would be very grateful if you would **verify whether your library has access to the Journal at this point in time**, and if not, please ask your librarian to obtain access to the Journal for residents, medical students and other otolaryngologists who may not have a subscription through the societies. In addition to providing an important educational opportunity within the field of rhinology, the wider such access occurs, the more

rapidly a major impact factor will evolve for the Journal. Advertising, an important component for the long-term financial success of the Journal, has continued to grow nicely despite an overall tight economic environment.

With each edition, I have elected to either write myself, or have one of the Associate Editors write, an editorial highlighting some of the articles in the Journal and providing some additional perspective. I hope that you, as the readership, enjoy the editorial and I would welcome your feedback and other comments regarding IFAR.

Case of the Qtr, continued from pg 5

be under-recognized even amongst otolaryngologists. The aforementioned endoscopic findings and laboratory evaluation should raise clinical suspicion of sarcoidosis which should prompt directed biopsies to establish a histopathologic diagnosis. Corticosteroid therapy is the mainstay of management, and the role of FESS is limited and controversial.

References

1. Braun JJ, Gentine A, Pauli G. Sinonasal sarcoidosis: review and report of fifteen cases. *Laryngoscope*. Nov 2004;114(11):1960-1963.
2. Baughman RP, Lower EE, du Bois RM. Sarcoidosis. *Lancet*. Mar 29 2003;361(9363):1111-1118.
3. McCaffrey TV, McDonald TJ. Sarcoidosis of the nose and paranasal sinuses. *Laryngoscope*. Oct 1983;93(10):1281-1284.
4. Aubart FC, Ouayoun M, Brauner M, et al. Sinonasal involvement in sarcoidosis: a case-control study of 20 patients. *Medicine (Baltimore)*. Nov 2006;85(6):365-371.
5. Reed J, deShazo RD, Houle TT, Stringer S, Wright L, Moak JS, 3rd. Clinical features of sarcoid rhinosinusitis. *Am J Med*. Sep 2010;123(9):856-862.
6. Tay HL, Vaughan-Jones R, Qureshi SS. Ethmoidal sarcoidosis. *J Laryngol Otol*. Aug 1994;108(8):682-684.
7. Dessouky OY. Isolated sinonasal sarcoidosis with intracranial extension: case report. *Acta Otorhinolaryngol Ital*. Dec 2008;28(6):306-308.
8. Fergie N, Jones NS, Downes RN, Bingham BJ. Dacryocystorhinostomy in nasolacrimal duct obstruction secondary to sarcoidosis. *Orbit*. Sep 1999;18(3):217-222.
9. Wilson NJ, King CM. Cutaneous sarcoidosis. *Postgrad Med J*. Nov 1998;74(877):649-652.
10. Kay DJ, Har-El G. The role of endoscopic sinus surgery in chronic sinonasal sarcoidosis. *Am J Rhinol. Jul-Aug 2001;15(4):249-254*.
11. Long CM, Smith TL, Loehr TA, Komorowski RA, Toohill RJ. Sinonasal disease in patients with sarcoidosis. *Am J Rhinol*. May-Jun 2001;15(3):211-215.

Rhinology Perspectives, continued from previous page

as a biocide with antibiofilm capabilities. In a prospective uncontrolled study, 1% baby shampoo irrigations improved overall symptoms, mucus thickness, and post-nasal discharge in refractory CRS patients (Chiu 2008). However, a subsequent RCT did not demonstrate any significant differences in symptoms, QOL, or olfaction thresholds between CRS patients given 1% baby shampoo irrigations vs. HS following routine ESS (Farang 2012). Issues with patient tolerability (nasal burning, headache), ciliotoxicity, and smell disturbances have also been reported depending on the type of surfactant used. Thus, although topical additives may have a promising role as adjunctive treatment for recalcitrant CRS, more studies are needed to investigate their clinical efficacy in comparison to other agents and establish respective safety profiles.

CONCLUSION: The use of topical therapies for the treatment of CRS has expanded in scope and popularity over the past decade. The evidence is strongest for the use of saline irrigations but efficacy studies have been mixed over the use of topical anti-infectives, anti-inflammatories and other additives such as surfactant solutions. Despite this, these topical therapies retain promise in the treatment of post-ESS patients who remain symptomatic despite adequate technical surgery and the use of topical steroid sprays and saline irrigations. Further research is needed to better elucidate the patient populations who will most benefit from each individual irrigation as well as to limit local side effects.

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If you would like have your upcoming rhinology meeting noted here, simply provide the editor with pertinent information: newsletter@american-rhinologic.org
The American Rhinologic Society does not endorse these meetings but simply provides the list as a service to its members.
The content of Nose News represents the opinions of the authors and does not necessarily reflect the opinions of the American Rhinologic Society.

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The American Rhinologic Society wants YOU!

Note from the President:

If you are a general otolaryngologist working in a community setting, the American Rhinologic Society wants you! We want you to be a member, and we want you to participate in the committee structure and leadership of the society. The ARS is the only society within otolaryngology dedicated to promoting education, research, and advocacy issues related to rhinology, sinus, and skull base surgery. Our journal, *International Forum of Allergy and Rhinology*, is the largest circulation rhinology journal presenting cutting edge and relevant rhinology information in an age of Maintenance of Certification-- and it's a benefit of your membership. In short, the American Rhinologic Society deals with the issues you deal with and is concerned with the issues you are concerned with. Numbers matter - **please consider joining, and getting involved, in our society.**

Please return to: American Rhinologic Society, PO Box 495, Warwick, NY 10990

Fax: 845-986-1527, Email: ars.administration@gmail.com

Please Print Clearly:

First Name: _____ Last Name: _____ Degree: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Tel: _____ Ext. _____ Fax: _____

Email: _____ Web Address: _____

The ARS wants to serve our members. Please help us get to know you. Please list issues that you feel are important to the field of Otolaryngology:

- 1) _____
- 2) _____

Please list committees that you may be interested in participating in: For a complete list of ARS committees, please go to www.american-rhinologic.org

- 1) _____ 2) _____
- 3) _____ 4) _____

Are you in Private Practice? Yes No

Current Hospital affiliation: _____ Academic Title: _____

Have you ever attended an ARS meeting? Yes No If yes, when? _____