



# AMERICAN RHINOLOGIC SOCIETY NEWSLETTER

March 2000

Volume 20, No. 14

## President's Message



**Charles W. Gross, M.D.**  
President

*After the lull of the Holidays and preoccupation with Y2K matters all of us are now accelerating our activities. This is certainly true for the American Rhinologic Society. Your Executive Committee met in December and outlined plans for this year. As you know Dr. Stucker's term as Secretary soon ends and the Nominating Committee, headed by Dr. Panje, is in the progress of reviewing the qualifications of applicants and will nominate a successor for Dr. Stucker*



**COSM Convention Hotel in Orlando**

*to be considered at the Spring Meeting.*

*Many committee assignments have been made, but there are some vacancies remaining and if you would like to participate in one of these committees, please let me or Dr. Toffel know soon. Most committees will meet on Saturday, May 13<sup>th</sup> at COSM.*

*Dr. Kuhn is putting the final touches on the Spring Scientific Program. I believe this will be one of our best programs ever. Also, the Triologic Society will feature Rhinologic subjects on the morning of Tuesday, May 15<sup>th</sup>, preceding the ARS Scientific Program that afternoon. There will be a panel chaired by Dr. Dave Kennedy, "New Front Careers and Development in Rhinosinusitis", and Dr. Gustof Fernström, invited rhinologic guest speaker for the Triologic Society, will deliver an address on "Recent Advances in Rhinology - A Northern Europeans Prospective". He will also speak at the ARS meeting. Other rhinologic presentations at the Triologic Society will be as close to our Tuesday time slot as possible. You are invited to register for the Triologic Society Meeting and to attend these and other presentations.*

*I will be representing the American Rhinologic Society at two forthcoming meetings. The Sinus and Allergy Health Partnership will have a strategic planning session on March 3<sup>rd</sup>. After polling the Board of Directors I will present our opinion that the Partnership is working well and accomplishing much on behalf of all otolaryngology; however, we would like to see a greater emphasis on the fact that otolaryngologists are the expert providers for problems in the nose and sinuses and, therefore, should be the referral source from primary physicians and others for patients needing expert medical and surgical management of conditions pertaining to the nose and sinuses. I will also be representing the ARS at the joint meeting of the presidents of all Otolaryngology Societies, chaired by the American Board of Otolaryngology.*

*If you have special concerns and input you feel should be presented at these meetings, or other concerns in reference to the Society, please contact me at [cwg9u@virginia.edu](mailto:cwg9u@virginia.edu). Again, it is a pleasure working on behalf of the Society and with your elected leadership. Thank you for this privilege.*

## What's Inside ...

President-Elect's  
Message . . . 2

COSM Schedule and  
Information . . . 2 & 3

Treatment of Allergic Fungal  
Sinusitis . . . 4

When Your Sinus Surgery  
Patient Has Allergies . . . 5

Fall Meeting Electronic  
Abstract Information . . . 6

Treasurer's Report . . . 7

Socioeconomic Update . . . 8

Editorial Info . . . 8



## President-Elect's Message

Dear Colleagues: Time is fast approaching for our Spring 2000 ARS Meeting at COSM in Orlando. We will meet in conjunction with the AAFPRS on Sunday, May 14, 2000, and then will have two afternoon sessions on Monday, May 15<sup>th</sup> and Tuesday, May 16<sup>th</sup>. I believe we have an exciting program to look forward to with 35 papers,

**Frederick A. Kuhn, M.D.**

two guest speakers and wide variety of clinical papers. On Monday Dr. Joel Bernstein will speak on "The Molecular Biology of Inflammation" and the panel will focus on osteitis, facial pain, osteoneogenesis and inflammation. Following this on Tuesday Professor Gustaf Fernstrom from Sweden will speak on "New Advances in Rhinology: The Northern European Experience."

The editorial change for CPT Code #61795 is now in the new 2000 CPT code book. The new word descriptor for the procedure is Stereotactic Computer Assisted Volumetric (Navigational) Procedure; Intracranial, Extracranial or Spine. Consequently, this code can now legitimately be used by otolaryngologists, neurosurgeons and orthopedists for extracranial and spine procedures. Our procedures at the skull base and in the sinuses whether termed Image Guided Surgery, Computer Assisted Surgery or Frameless Stereotactic Surgical Navigation can all be coded with this number.

Another issue, which is cropping up more frequently, is the proclivity of insurers to deny payment for turbinate and septal surgery performed at the same sitting. If you are experiencing this, please let us know.

I look forward to seeing you in Orlando!

Frederick A. Kuhn, M.D.  
President-Elect, ARS  
Savannah, Georgia

## Preliminary Program for the ARS Spring 2000 Meeting (dates and times are subject to change)

Orlando World Center Marriott  
8701 World Center Drive  
Orlando, Florida 32821  
#800-621-0638

### Monday, May 15, 2000

- 1:00 – 1:08 PM Neuronal Proliferation in the Olfactory Mucosa: The Effects of Dexamethasone in Vivo ~ James N. Palmer, MD; David B. Conley, MD; Robert C. Kern, MD; Dimitri Z. Pitovski, MD
- 1:08 – 1:16 Evidence that Sensory Transduction in the Vomeronasal Organ is Mediated by Phospholipase C, but not Adenylyl Cyclase ~ Andrew P. Lane, MD; Roland Block; Trese Leinders-Zufall, Ph.D.; Frank Zufall, PhD
- 1:16 – 1:24 The Porcine and Lagomorph Septal Cartilages: Models for Tissue Engineering

- 1:24 – 1:32 and Morphologic Cartilage Research ~ Brian J. F. Wong, MD; Hong K. Kim, BS  
Analysis of the Sinus Lateralis ~ Christopher B. Mawn, MD; William Bolger, MD, FACS
- 1:32 – 1:40 Discussion
- 1:40 – 1:48 Chronic Sinonasal Disease in Patients with Sarcoidosis ~ Christopher M. Long, MD; Todd A. Loehrl, MD; Timothy L. Smith, MD, MPH; Robert J. Toohill, MD, FACS
- 1:48 – 1:56 The Role of Endoscopic Sinus Surgery in Chronic Sinonasal Sarcoidosis ~ David J. Kay, MD; Gady Har-El, MD
- 1:56 – 2:04 Bony Abnormalities of the Nose and Paranasal sinuses in Waegner's Granulomatosis ~ Caroline Yang, MD; Michael Talbot, MD; Peter Hwang, MD
- 2:04 – 2:12 Histopathologic Evaluation of the Ethmoid Bone in Chronic Sinusitis ~ Renato Giacchi, MD; Richard Lebowitz, MD; Joshua Light, MD; Joseph B. Jacobs, MD; Herman Yee, MD
- 2:12 – 2:20 Discussion
- 2:20 – 2:50 Speaker – Joel Bernstein, MD "Molecular Biology of the Upper Respiratory Tract, Using a Nasal Polyposis Model"
- 2:50 – 3:00 Discussion
- 3:00 – 3:15 Break
- 3:15 – 4:00 Panel – Osteitis, Facial Pain and Osteoneogenesis  
Moderator – Frederick A. Kuhn, MD  
Wm. E. Bolger – Gram Negative Sinusitis and Osteitis  
David W. Kennedy – Bone Pathology in Osteitis  
Joel Bernstein, MD – Molecular Biology of Osteitis Pain  
Frederick Garner - Treatment of Osteitis/Osteoneogenesis
- 4:00 – 4:08 Endoscopic and Radiologic Evaluation of the Causes of Functional Endoscopic Sinus Surgery Failure: Review of 60 Consecutive Cases ~ Winston Vaughan, MD
- 4:08 – 4:16 The Use of Porous Polyethylene Implants to Correct Nasal Valve Collapse ~ Suzanne Yee, MD; Chris Danner, MD
- 4:16 – 4:24 The Use of Mitomycin-C to Reduce Adhesion Formation Following Sinonasal Surgery ~ Mathew J. Cosenza, DO; Ralph Metson, MD; Reza Rahbar, MD, DMD
- 4:24 – 4:32 Endonasal Management of Cerebrospinal fluid (CSF) Rhinorrhea ~ Lincoln H. Lippincott, MD; Jan Maurer, MD; Ronald G. Amedee, MD; Wolf J. Mann, MD
- 4:32 – 4:40 Use of an Electronic Nose to Distinguish CSF from Serum in Patients With Suspected CSF Leak ~ Erica R. Thaler, MD; David W. Kennedy, MD; C. William Hanson, MD
- 4:40 – 4:48 A Four Year Review of Transnasal Endoscopic Hypophysectomy: The Minimally Invasive Approach ~ Shawn S. Nasser, MD; Jan L. Kasperbauer, MD; Scott E. Strome, MD; Thomas V. McCaffrey, MD, Ph.D., Jon L. Atkinson, MD
- 4:48 – 5:00 Discussion

**Tuesday, May 16, 2000**

- 1:00 – 1:08 PM *Utility of Intraoperative CT-Guided Endoscopic Sinus Surgery: A National Survey* ~ Jeffrey A. Livingston, MD; Rodrigo A. Bolanos, MS; Roy R. Casiano, MD, FACS
- 1:08 – 1:16 *Complications of Image-Guided Functional Endoscopic Sinus Surgery* ~ Winston Vaughan, MD
- 1:16 – 1:24 *Malleable Registration Mask for Image Guided Surgery* ~ John M. DelGaudio, MD; Todd Kingdom, MD
- 1:24 – 1:32 *Postoperative Antibiotic Use Following FESS: Practice Habits of the American Rhinologic Society, A Survey* ~ Mark K. Wax, MD; R.V. Paolini, MD; J.S. Rechtweg, MD; Michael Belmont, MD; Catherine Winslow, MD
- 1:32 – 1:40 *Gentamicin Nasal Irrigation Induced Ototoxicity* ~ Michael A. Fritz, MD; Robert R. Lorenz, MD; John G. Oas, MD; Donald C. Lanza, MD
- 1:40 – 1:48 *Pathogenesis of Viral Induced Rhinosinusitis in the Mouse* ~ Robert B. Meek III, MD; George S. Dawson, MD; Alfred Berrebi, Ph.D.; Hassan Ramadan, MD
- 1:48 – 1:56 *Discussion*
- 1:56 – 2:04 *Granulocyte Transfusion in the Management of Fulminant Invasive Fungal Sinusitis* ~ Daniel S. Samadi, MD; Richard R. Orlandi, MD; Andrew Goldberg, MD
- 2:04 – 2:12 *Endoscopic Sinus Surgery for Stage IV Hyperplastic Rhinosinusitis: Outcomes Assessment* ~ Markus Gapany; Trang Vo-Hguyen; Kathy Daly; George Goding; Holly Boyer
- 2:12 – 2:20 *Endoscopic Resection of Ethesioneuroblastomas* ~ Roy S. Casiano, MD, FACS; William A. Numa, MD; Alberto M. Falquez, MS
- 2:20 – 2:28 *Endoscope Assisted Craniofacial Resection: A Case Presentation with Review of the Literature* ~ Ashutosh Kacker, MD; Jerry Huo, MD
- 2:28 – 2:36 *Computed Tomography Findings in Patients with Invasive Fungal Sinusitis* ~ Ron Swain, Jr., MD; Todd Kingdom, MD; Susan Muller, MD; John DelGaudio, MD; Patricia Hudgins, MD
- 2:36 – 2:44 *Utility of Computed Tomography and Magnetic Resonance in Invasive Fungal Rhinosinusitis* ~ R. Charles Howells III, MD; Hassan H. Ramadan, MD



- 2:44 – 2:52 *Rathke's Cleft Cyst, Diagnostic and Therapeutic Considerations for the Otolaryngologist* ~ Jan L. Kasperbauer, MD; Laura J. Orvidas, MD
- 2:52 – 3:00 *Discussion*
- 3:00 – 3:15 *Break*
- 3:15 – 3:45 *Speaker – Gustaf Fernstrom, M.D. "Recent Advances in Rhinology: The North European Experience."*
- 3:45 – 3:53 *Acoustic Rhinometry Findings in Patients with Mild Sleep Apnea* ~ Steven M. Houser, MD; Bulent Mamikoglu, MD; Benjamin F. Aquino, BS; Jaquelynne P. Corey, MD, FACS, FAAOA
- 3:53 – 4:01 *Treatment of Hypoxemia in Obstructive Sleep Apnea* ~ Michael Friedman, MD; Roy Landsberg, MD; David Caldarelli, MD
- 4:01 – 4:09 *Reflux and Chronic Sinusitis: Are They Related?* ~ Stacey Silvers, MD; Henry Kim, MD; Scott Gold, MD; Robert Pincus, MD
- 4:09 – 4:17 *Creating an Osteoplastic Flap: A Quantitative Comparison of Three Techniques* ~ Michael H. Callahan, MD
- 4:17 – 4:25 *Discussion*
- 4:25 – 4:33 *Histomorphometric Analysis of Human Sphenoid and Maxillary Mucosa: Measurement of Relative Density of Goblet Cells and Basal Cells* ~ Shane R. Smith, MD; Margaret Brandwein, MD; William Lawson, MD, DDS
- 4:33 – 4:41 *Effective Application of Nasal Steroid Spray in common Practice* ~ Richard A. Lebowitz, MD; Suzanne K. Doud Galli, MD, Ph.D.; Renato Giacchi, MD
- 4:41 – 4:49 *The Middle Meatal Antrostomy: Is it Necessary?* ~ Peter Catalano, MD, FACS; Reuben Setliff III, MD
- 4:49 – 4:57 *Unusual Paranasal Sinus Tumors Presenting with Common Nasal Complaints* ~ Hannah Vargas, MD; Lisa T. Galati, MD
- 4:57 – 5:05 *Discussion*
- Don't delay! COSM 2000 early registration must be post-marked by April 14, 2000, and forms received after April 28, 2000, will not be accepted. For more COSM registration information, visit the AAO-HNS website at [www.entnet.org](http://www.entnet.org) or call fax on demand by calling #888-292-2703 and punch in:*
- #6240 for COSM Schedule
  - #6241 for COSM Registration Form
  - #6242 for COSM Housing Reservation/ Transportation Information
  - #9501 for the index





**Berrylin Ferguson, M.D.**

## **Allergic Fungal Rhinosinusitis (AFRS) – Diagnosis and Treatment**

AFRS has been appreciated for almost 20 years based on its histopathologic findings of eosinophilic mucin with scattered fungal hyphae. The pathophysiologic basis for AFRS is an IgE

mediated hypersensitivity to the fungus present in the mucin. The atopic individual responds to the antigenic inhaled spores by secreting mucin, in which the spore germinates and the hyphal elements grow. This causes increased antigenic stimulation followed by increased production of allergic mucin and nasal polyps. Special fungal stains are often required to see the hyphae. Fungal cultures may be falsely positive and may fail to grow even in AFRS. The most common fungi associated with this entity are *Bipolaris* species, *Curvularia*, *Alternaria*, and *Aspergillus* species. The disease is the same regardless of the fungal pathogen. AFRS can lead to erosion of the bony walls of the orbit and the skull base. In children, presumably with their more malleable bony structure, proptosis is common. Invasion by the fungus has not been convincingly shown in any cases of AFRS.

AFRS is unilateral in almost half of all cases and occurs more commonly in children and young adults, although it may occur at any age and occurs almost equally in males and females. Polyps are usually present and frequently the patient can intermittently expel the characteristic rubbery, greenish mucin. Histopathologic examination of these plugs frequently reveals hyphae present in allergic mucin, and thus solidifies the diagnosis of AFRS. Computed tomographic imaging frequently discloses heterogeneity of the soft tissue densities, with the allergic mucin appearing as a denser mass surrounded by the mucosal hypertrophy and polypoid changes of the nose and sinuses. On Magnetic Resonance Imaging the proteinaceous character of the allergic mucin may lead to a signal void on T2 weighted images. Although this is suggestive of AFRS, it is not diagnostic, since any dense proteinaceous material in the sinuses may cause a similar image.

The treatment of AFRS is grounded first on diagnosis. Frequently the sinus surgery that leads to diagnosis is curative, by removing large amounts of the fungal infested mucin. The microdebriders have greatly aided extirpation of this tenacious mucin. They must be used with caution adjacent to bony dehiscences. Persistence or reinfestation is common, occurring in over half of all cases. Systemic corticosteroids, which down regulate the entire inflammatory cascade, are an important adjunct in alleviating symptoms and prolonging disease free intervals. Nevertheless, systemic steroids are associated with significant side effects, including osteoporosis, glaucoma, cataracts, glucose intolerance, exacerbation of peptic ulcer disease, hypertension, hypothalamic-pituitary axis suppression, personality changes and growth suppression in children.

The role of topical nasal steroids (NSS) in AFRS is not well studied, nevertheless most practitioners prescribe

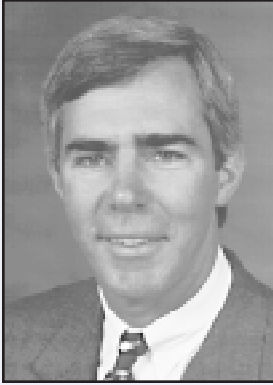
them because of their low incidence of adverse side effects and the theoretically efficacy of a potent topical steroid in inflammatory disease. AFRS occurs because of an allergy to the fungus present in the mucous, and thus it is not much of an extension to assume that NSS's would be effective in AFRS, since NSS's have been shown to be effective for symptomatic relief of allergic rhinitis.

Antifungal therapy has been advocated in cases of AFRS but no controlled studies have been performed. Several years ago, a study of the pulmonary form of the disease, allergic broncho-pulmonary aspergillosis (ABPA) showed that children with cystic fibrosis and ABPA required less prednisone and had a fall in total IgE with oral Itraconazole therapy. Anecdotally, the author has had one patient intolerant of oral steroids, whose AFRS resolved with a six-week course of Itraconazole. The usual dosage recommended by Manrin Rains, MD (Tennessee) and Rueben Setliff, MD (South Dakota) is Itraconazole 100 mg, 4 tablets orally per day for two to four weeks, and tapered to 200 mg a day for an additional two to four weeks, and finally to 100 mg a day for an additional month. Itraconazole requires acidity for optimal absorption, and thus cannot be taken with antacids. Rare hepatic toxicity has been reported. A course of Itraconazole at a dosage of 400 mg a day for one month is more than \$700. Before long courses of Itraconazole can be widely advocated controlled trials must be performed.

Over the last five years, Mabry and colleagues in Dallas Texas have published several studies of the response of patients to immunotherapy (IT) following surgical removal of the allergic fungal mucin. IT was initially initiated with fungal antigens and later other inhalants were added. They demonstrated no adverse reaction from fungal IT and subsequently in a case-controlled study showed that IT decreases the rate of recurrence compared to patients electing to forgo IT. After 3 to 5 years, Mabry and colleagues stopped IT and the studied patients had no recurrence of disease in a follow up of less than 18 months. *Bipolaris* is one of the most common causes of AFRS. Unfortunately, there is no commercially available *Bipolaris* antigen. Most patients are allergic to many molds. Antigenically *Helminthosporium* is closest to *Bipolaris*, and many investigators substitute it for *Bipolaris*.

The current state of treatment for AFRS lies first in its diagnosis. The cornerstone of diagnosis is presence of the characteristic histopathology, which shows eosinophilic mucin with hyphae present. The treatment consists of conservative surgical exenteration, often with endoscopic techniques using the microdebrider. Perioperative steroids are frequently administered to reduce the inflammatory stimulation of surgery and tapered over one to several weeks. Postoperative IT, containing any fungal antigens to which the patient is allergic or which grow from the mucin, is instituted within 4 to 8 weeks postoperatively. A preliminary short-term study suggests that after 3 to 5 years, IT may be stopped without risk of recurrence of AFRS. Validation of these promising findings awaits a multicenter-randomized trial.

Berrylin J. Ferguson, M.D., Board of Directors, ARS University of Pittsburgh, Pittsburgh, Pennsylvania



## **When your Sinus Surgery Patient has Allergies**

*Allergic Rhinitis afflicts 17-22% of the US population and is the second most common factor responsible for chronic or recurrent rhinosinusitis. Otolaryngic surgeons need to be cognizant of the management of the allergic patient as they undergo Endoscopic Sinus Surgery*

*because good allergy care of these patients will enhance a smoother pre and post-operative course. The surgeon and patient will reap the rewards of improved outcomes of the proposed sinus surgery.*

*In atopic patients, the nasal membranes are subject to the release of several chemical mediators (histamine, leukotrienes, and certain chemokines) that create the edema and increased vascular permeability characteristic of the allergic state. Late stage inflammatory cells are more prevalent within the mucosa such as eosinophils, neutrophils and basophils. The eosinophils with their granules containing major basic protein, and eosinophilic cationic protein, are the most toxic and breakdown of these cells may potentiate post-operative edema formation. Allergic management seeks to stabilize the early and late stage reactions and thus reduce not only the patient's symptoms, but also improve function of the nasal and paranasal membranes.*

*Preparation for Endoscopic Sinus Surgery for either functional or hyperplastic polypoid disease requires appropriate pre-operative re-evaluation of the patient's allergic status. Appropriate allergy management prior to surgery enhances the surgical outcome. The analogy is the general surgeon's bowel prep. Emergency sinus procedures preclude the luxury of proper pre-operative allergy care, but even these patients will benefit from good post-operative management of their allergy problems.*

*The history at the initial consultation will determine the tendency for allergic rhinitis. The reactive allergic nasal membranes are more responsive "in season" so the history is important to the surgeon. Sinus surgery is not contraindicated in the hay fever season, but stabilizing the reactive inflammatory process may avoid the excessive mucus drainage and possible edema resulting from the combined surgical and allergic attack on these membranes. Good environmental control needs to be stressed to the patients with perennial (dust and mold) allergy. Air-conditioned (filtered air) will reduce the total allergic load as well. Institution of immunotherapy 6-12 weeks prior to surgery is helpful.*

*A review of the patient's medications is mandatory especially in regard to their usefulness and compliance. Allergic patients may have a closet full of medications such as antihistamines, mucus thinners, inhaled or topical steroids, bronchodilators and anticholinergics.*

*Certain first generation antihistamines tend to have an anticholinergic drying effect on the mucosa, and a switch to the newer generation may alleviate this effect. Antihistamines are useful and should be continued through the entire pre and post-operative course.*

*Topical nasal steroids are very efficacious in reducing the inflammatory state, but to be effective they need to reach the involved mucosa. Patients with large anatomic obstructions (deviated septum, large turbinates, or polyps) may not achieve relief with these medications. Instruction and guidance in proper topical nasal steroid use is very helpful. If the patient is already on a topical nasal steroid prior to surgery, they should continue up to the day of surgery. However the usual rule is to delay re-starting the intranasal steroid in the immediate post-operative course due to irritation of the mucosa for about 7 -10 days. Several surgeons have advocated intratubinal steroid injections at the end of surgery and this technique may be desirable in the highly reactive patient.*

*The acute inflammatory allergic reaction is usually immediately moderated by a loading dose of systemic cortico-steroids. Many of these allergy patients have received steroids in the past, and peri-operative and intra-operative systemic steroids may be required to avoid adrenal stress. Post-operative steroid taper is not necessary except in patients in the middle of a seasonal flare, or in patients with severe hyperplastic polypoid disease.*

*Sinusitis, allergic rhinitis and asthma co-exist in many patients undergoing sinus surgery. Asthma is now defined as an inflammatory state with chemical mediator release akin to allergic rhinitis. Bronchospasm results from liberation of chemokines and asthmatic flares may occur during or after surgery, leading to increased reactive airway disease. Pre-operative management of the asthmatic patient involves careful instruction and use of inhaled corticosteroids and beta-agonists. These medications stabilize the reactive airway. Asthmatic reactions post-operatively should be managed with a tapering short course of systemic steroids.*

*Hopefully these hints will assist all sinus surgeons to be diligent in their regard for the patient with significant allergic rhinitis or allergic asthmatic bronchitis preparing for sinus surgery.*

*James A. Hadley, MD, FACS  
Chairman, By-Laws Committee, ARS  
Rochester, New York*





## Electronic Abstract Submission Announcing the e-Abstract Module at [www.american-rhinologic.org](http://www.american-rhinologic.org)

Over the past several weeks, the ARS has updated its Internet site ([www.american-rhinologic.org](http://www.american-rhinologic.org)) so that the site now supports on-line abstract submission and review. Abstracts for the Scientific Sessions of the Fall Meeting should now be submitted on-line. In addition, abstracts for the Nose 2000 meeting should also be submitted through the ARS e-Abstract Module.

The e-Abstract Module has the following features:

- **Martin J. Citardi, M.D.** · Access to the administrative functions and abstract review process is password-protected on a secure server.
- All members and guests can submit their abstracts via the abstract submission page.
- Following submission, the corresponding author will receive an email that confirms receipt of the submission.
- The members of the review committee will receive email notification when abstracts have been received and are ready for review.
- Abstract review will be performed via the Internet. All review decisions will be made in a blinded-fashion.
- After the abstracts have been reviewed, the e-Abstract Module will rank the abstracts according to their scores. The Program Committee chairperson then will select the minimum score for acceptance. Notification of abstract acceptance/rejection will be sent out to the corresponding authors via e-mail automatically.
- The e-Abstract Module will also generate a master document of accepted abstracts; this master document may then be manipulated for creation of the meeting program and schedule.

In order to access the e-Abstract Module, please point your browser to [www.american-rhinologic.org](http://www.american-rhinologic.org). The abstract section of the site is under the "Abstracts" tab in the "Member Information" area of the site. A direct link to the e-Abstract Module is also present on the homepage.

Paperless abstract submission and review will offer many advantages. Obviously, the inconvenience of making text fit into boxes on forms is completely avoided. The review process will be enhanced since all reviews will be blinded, and the nuisance of faxes and overnight mail will be eliminated. Creation of the abstract program will be easier. Submissions from other nations will also be much easier.

It is anticipated that the e-Abstract Module (as well as the rest of the ARS Internet site) will undergo periodic updating. If you have any suggestions, please let us know.

Finally, please remember to submit all of your abstracts for both the Fall ARS Scientific Sessions and the Nose 2000 meeting via the ARS Internet site.

Martin J. Citardi, M.D.  
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## Treasurer's Report

As the incoming Treasurer of the American Rhinologic Society, I am pleased to find the society in sound financial shape and I would like to express my sincere thanks to Gene Kern for his excellent stewardship of the Society's resources. In part, the Society's current financial resources have been

developed through enormous success of the Corporate Sponsors Program under the direction of Paul Toffel. However, these latter resources are earmarked for continued development of the Society's research awards program and therefore must be identified separately. Encouraging and supporting young physicians to develop an interest in rhinologic research through the resources of this fund is essential if otolaryngologists are to be able to maintain their leadership within the field of rhinology in the coming years.

The Society is also committed to continuing its educational endeavors and, in the current economic environment, must also continue to utilize significant resources to ensure appropriate socioeconomic representation for its membership. However, legal representation on issues such as FESS reimbursement, or dealing with inappropriate bundling of codes, or interacting with third party carriers on issues such as global periods, although critical, are expensive. The operating expenses of the Society, including its ability to pay for copies of a rhinologic journal at no additional cost to the membership, are entirely dependent on the income from dues and meetings.

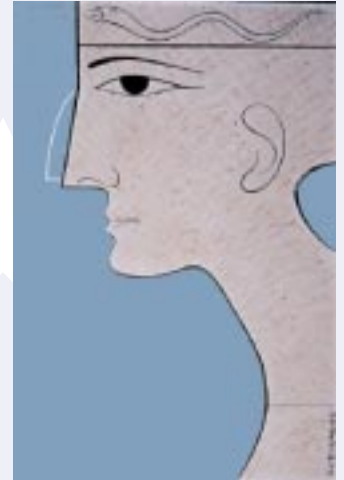
As Treasurer therefore, I must ask each and everyone of you who has not yet paid their year 2000 dues, to do so without delay. We need this income to continue to strengthen our mission, and particularly to continue to develop our socioeconomic activity on behalf of our membership. I have asked the Board to take a tough stance on Members who do not pay dues in a timely fashion. We have done a significant amount on behalf of the membership already, but we intend to increase this activity in the future. Please ensure that your American Rhinologic Society dues have been paid for this year and then participate in this Society which embraces the heart of our otorhinolaryngologic specialty.

David W. Kennedy, M.D., Treasurer, American Rhinologic Society, University of Pennsylvania, Philadelphia, Pennsylvania

## On the International Front . . .

Barcelona hosted the European Rhinologic Society Congress in 1972 and twenty-eight years later it again is the host for the XVIII Congress of European Rhinologic Society (ERS) and the XIX International Symposium on Infection and Allergy of the Nose (ISIAN) and in collaboration with the American Rhinologic Society, the International Rhinologic Society, the European Academy for Facial Plastic Surgery, the European Academy of Allergology and Clinical Immunology, the "Sociedad Espanola de O.R.L. y Patologia Cervico-Facial" and the "Societat Catalana d'O.R.L."

The venue of the Congress is the Barcelona Congress Centre (Palau de Congressos), located in downtown Barcelona near the "Placa d'Espanya" within the Trade Fair Complex, at the foot of the Montjuic. The meeting will be June 25 - 29, 2000. This combined congress is held every two years and the focus is to showcase the latest developments in rhinology: basic research, immunology, allergology, pathophysiology, diagnosis, medical treatment and surgical treatment.



Here are three ARS members who will be presenting:

"The Use of Autogenous Cartilage Grafts in Revision Nasal Surgery"

**Fred J. Stucker, MD, FACS**

Department of Otolaryngology - LSUHSC  
1501 Kings Highway  
Shreveport, Louisiana 71130-3932

"Treating the Patient Before the Pathology in Secondary Rhinoplasty"

**Daniel Daube, MD**

200 Doctors Drive  
Panama City, Florida 32405-4559

"Implants in Revision Rhinoplasty"

**Thomas Romo, III, MD, FACS**

1049 5<sup>th</sup> Avenue  
New York, New York 10028

For more information visit the website at [www.rhinology2000.com](http://www.rhinology2000.com) or e-mail [secretariat@rhinology2000.com](mailto:secretariat@rhinology2000.com)

**American Rhinologic Society**  
**Fred J. Stucker, M.D.**  
**1501 Kings Highway**  
**Post Office Box 33932**  
**Shreveport, LA 71130-3932**

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**Joseph Jacobs, M.D.**

### **Socioeconomic Update**

*The American Rhinologic Society obtained legal counsel through the Socioeconomic Committee concerning insurance carrier policy with respect to post FESS coding of 31237 and 31231 for reimbursement. Certain third party payers are flagrantly ignoring Medicare policy with respect to global surgical periods while simultaneously alleging to follow Medicare's resource-based relative value scale to set payment. However, the global surgery period is inextricably linked to payment values. It appears unreasonable, and at times unlawful, for a payer to suggest that it is setting its payments based on the Medicare fee schedule, yet refusing to adopt Medicare's global payment policy.*

*The ARS encourages members to challenge inappropriate payer policies and request that the payer provide its authority to establish a 90-day global period for FESS procedures. HCFA assigned payment values for FESS assuming that medically necessary subsequent diagnostic endoscopies (CPT code 31231) or surgical endoscopies with debridement (CPT code 31237) would be reimbursed separately as outside the zero-day global period.*

*In summary, physicians who are denied payment for post-operative FESS endoscopies should vigorously appeal these denials. The ARS and our Socioeconomic Committee through our legal counsel will provide support of our members in this endeavor. For a more detailed discussion of the topic, please see ARS Newsletter, Vol 20. No. 13, November, 1999.*

*HCFA has agreed to permit the use of CPT code 61795 for stereotactic assistance in sinus surgery. This change occurred through a joint effort of the AAO-HNS, the ARS and the Neurosurgery organizations. However, HCFA has not yet agreed to allow bilateral coding for CPT codes 30930 (outfracture of turbinates), 30130 (turbinectomy), and 30140 (submucous resection, turbinate). Please channel all your questions and data through the Chairman of the Socioeconomic Committee.*

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