

## PRESIDENT'S MESSAGE



James Hadley, MD,  
FARS, President

With the onset of spring, comes a refreshed view for the American Rhinologic Society. After the winter doldrums, comes a new view of the future, and we are now able to look forward to some exciting changes and opportunities

for the Society.

The American Rhinologic Society is over 1000 members strong and is the third largest subspecialty in Otolaryngology. If most of you are members like myself, we have been working hard through the winter months in our clinical practices. The Annual meeting in Orlando gave us a wealth of opportunity to advance our knowledge and many of us learned a great deal over the last year and are applying our educational experiences to our patient population. We look forward to all of the upcoming programs to enhance the knowledge base that has already been established.

Our 50th anniversary celebration plans are starting to mold into a cohesive educational program. The 50th anniversary committee continues its preparations for the September 18-20 meeting at the New York City Hilton. Members can obtain registration forms at the American Rhinologic Society web site ([www.American-Rhinologic.org](http://www.American-Rhinologic.org)) and we encourage you to stay within the hotel block and especially at the New York Hilton. This will facilitate your travels as the distances in New York City become somewhat difficult between adjacent meetings.

Due to an unanticipated coincidence with the religious holidays, the program Committee saw fit to move the educational meeting to begin on Saturday afternoon. The program will continue on Saturday evening with an educational dinner as well as a special historical review of the American Rhinologic Society. At this dinner session, we will recognize our honored guest, Dr. David W. Kennedy. The program will continue on Sunday with special paper presentations, breakout sessions as well as instructional courses. On Sunday evening there will be a special reception sponsored by our corporate relations at the Rainbow Room in the NBC Building.

Come to New York City in September! You will witness an unprecedented number of Rhinologic applications and will be a part of our 50th Gala celebration.

The Spring Program at COSM was a tremendous educational experience with a dynamic scientific program. Dr. Joseph Jacobs and his program committee arranged an intriguing set of discussions focusing on surgical management, radiographic evaluation, antimicrobial issues, inflammation, olfaction, and ancillary techniques. Two different panel discussions interspersed



## SUMMER 2004

during the meeting looked at chronic rhinosinusitis in adults and children. As a result of the high activity of our membership, an overflow of excellent submissions led to a large poster session. Two excellent abstracts were also awarded educational travel grants

to the resident presenters from the AAO/HNS.

To all those who came, thanks for attending this rewarding scientific program.

On some other topics, I have the pleasure of working with Past President Dr. Donald Lanza on a combined Rhinologic and Allergy project to help us further define development of clinical trials for chronic rhinosinusitis. Our colleagues in general allergy invited representatives in Otolaryngology to assist in developing the definitions for clinical trials for this disease entity. As most of you know, there is no current medication that has any indication for chronic rhinosinusitis as this definition is not currently recognized by the Food and Drug Administration (FDA). Prominent members of the American Rhinologic Society including doctors Kennedy, Lanza, Marple, Hadley, Benninger, Ferguson, Piccirillo, Naclerio, Baroody, and Zinreich in addition to international otolaryngologists such as Valerie Lund, Claus Bachert, have played a major role in gathering information on this disease entity. We are working with our general allergy colleagues to pull together all of the research data and publications dealing with chronic rhinosinusitis. The end result of this will be a publication that, hopefully, will define methods for clinical trials in the management of chronic rhinosinusitis. Most of these definitions are still based on published definitions by the Sinus and Allergy Health Partnership. The document is almost ready for publication and you will be kept abreast of this information through this newsletter.

After the publication of the most recent Guidelines in the Management of Acute Bacterial Rhinosinusitis by the Sinus and Allergy Health Partnership, many other types of guidelines still try to emulate the work of members of the ARS who participated in this landmark work. Thanks to the diligence of the team of participants of the ARS (Drs. M. Benninger, J Hadley, D Lanza, D Osguthorpe and J Stankiewicz) this reference is now often quoted as the leading authority in the management of Rhinosinusitis. The ARS has played the major role in guiding the formation of these materials and continues to perform its mission of education.

Medical society like the American Rhinologic Society is always in transition. As technology advances, so has the American Rhinologic Society board in keeping up with updates. This applies to our ACCME accreditation. It is important for the secretarial office to remain diligent with the records of our scientific meetings under the scrutiny of the ACCME. To that end, the Board of Directors has approved the invitation of an educational consultant to assist the office of the Secretary in the management of the accreditation

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The American Rhinologic Society  
would like to thank Gyrus ENT  
for partnering with the ARS  
Newsletter for 2004

# ARS GOLDEN ANNIVERSARY MEETING

Joseph B. Jacobs, M.D., Program Chair, President-Elect ARS

The American Rhinologic Society will be celebrating our 50<sup>th</sup> Golden Anniversary in 2004. The Society has organized a 3 day scientific session which will commence on the afternoon of Saturday September 18 and conclude the morning of Monday September 20 in New York City at the Hilton Hotel 1335 Avenue of the Americas between 53 and 54 st. Our meeting will coincide with the American Academy of Otolaryngology Fall meeting. The venue of New York City as well as the simultaneous Academy meeting will attract many national and international attendees. David Kennedy will be our Guest of Honor and the faculty will include an unprecedented number of national as well as international experts within the field of Rhinology.

Jan Gosepath is coordinating the international faculty which includes; Heinz Stammberger, Wolf Mann, Valerie Lund, Claus Bachert, Christian Buchwald, Silvain Lacroix, Metin Onerci, Paolo Castelnuovo, Ranko Mladina, Vladimir Kozlov, Peter Clement, P J Wormald, Carlos Cuiltly-Siller, Piero Nicolai and Aldo Stamm.

The scientific program will include free paper sessions, instructional courses, moderated sessions, video and breakfast symposia as well as poster presentations. Saturday evening will feature a Gala 50<sup>th</sup> Anniversary Dinner at the Hilton Hotel honoring David Kennedy. On Sunday evening the ARS Presidential function will be at the Rainbow Room featuring cocktails and a light dinner. A historical presentation will feature the development of our society from 1954 and presentation of awards to past presidents.

Hotel accommodations will be available through the American Academy of Otolaryngology at [www.entlink.net](http://www.entlink.net) and click on the annual meeting link. In addition, budget accommodations are available through the NYC conventions and visitors bureau, [nycvisit.com](http://nycvisit.com)



## MANPOWER AND RHINOLOGY

Ron Cannon, MD

A recent manpower study has indicated several interesting trends as well as validating the primary role of Otolaryngology- Head and Neck Surgery in the treatment of nasal and sinus disease. This manpower study has determined key elements of the current workforce, scope of practice issues and geographic distribution of the specialty.

#### **Key findings of the study include:**

A ratio of 3.163 Otolaryngologists per 100,000 population. This is compared to a ratio of 2.962 Otolaryngologists per 100,000 population in 1995. This increased rate of Otolaryngologists is likely due to a decreased retirement rate of practicing Otolaryngologists due to current marketplace factors. Increased women in the workforce/ women up make up 8.2% up from 6.5% in 1995.

#### **Market force issues:**

- Flat or decreasing reimbursement in the face of increased expenses. (Especially malpractice premiums)
- Gatekeeper concept waning, more access to specialist

- Increased office practice, less surgery "Graying" of the specialty.

Largest number of practicing Otolaryngologists, ages 40-59, Improvement of the market with enhanced retirement portfolios pose a potential question regarding future needs for the numbers of practicing Otolaryngologists.

Technological advancements will continue to expand the horizons of the specialty. As regards nasal/sinus disease this study has documented the pre-eminence of the specialty. Several large national data sets (including Medicare) were examined to capture trends in nasal and sinus disease. These figures indicate that Otolaryngologists perform the vast majority of these procedures. Additionally the Otolaryngologist performs a large proportion of traditional facial plastic procedures, including rhinoplasty.

Continued technological advances as well as expanding scientific knowledge of the nose/sinuses will lead to new horizons in the care of patients with rhinologic disease.

# TREASURER'S REPORT

David W. Kennedy, M.D.



The goal of the Board of Directors of the Society and of the Treasurer's office continues to be to manage the society so as to maximize the benefit to our membership for their dues. I am pleased to report that the Board has succeeded in this goal. Considering that, as part of our \$240 dues payments, the Society subscribes on our behalf to one of two the leading Journal options within the subspecialty, I am sure that you can understand that this is indeed a tightly fiscally managed organization. The most significant expenses are those associated with our CME programs and meetings. With the exception of legal expenses associated with the advocacy efforts on behalf of our members, our successes in response to membership concerns have been largely based on unselfish volunteerism.

At the end of CY 2003, we had approximately \$200,000 in our operating account, up slightly from the prior year. However, there are significant potential financial liabilities involved in holding CME meetings today. Additionally, it is essential that we have the necessary financial buffer to be able to respond decisively with appropriate legal support when issues arise which may adversely affect our membership. Accordingly, I believe that this fund balance needs to be raised

somewhat over the coming year. Hopefully this will be aided by further improvement in the market.

The news letter is entirely paid for by commercial support. Additionally, although the Society provides grants to support both resident and attending research, this is not done with dues or operating funds. Rather this research support is entirely covered through the generosity of our Corporate Sponsors and the superb fundraising activities of Paul Toffel. Again, the society has elected not to carry a large research fund balance, but rather to provide maximum benefit to those who financially support this effort by passing the funds on with no administrative costs to those who are successful in the peer reviewed CORE grant process. At the end of CY 2003, our fund balance in this account was \$224,000.

Overall therefore, I believe that the Society is financially stable and represents a well run, lean and effective organization. It has been able to fulfill its educational mission and its efforts on behalf of the membership effectively. In the coming year, we should each work to increase our membership by encouraging our friends and partners to join. This will help the Society to improve its financial buffer, without increasing our very reasonable annual dues, and to remain effective in furthering this very important part of our specialty.

## WHY JOIN THE AMERICAN RHINOLOGICAL SOCIETY?

Membership in the American Rhinologic Society provides critical support that strengthens its ability to speak out on behalf of you, and all practicing Rhinologists. Since it was originally founded by Dr. Maurice H. Cottle in 1954, the American Rhinologic Society (ARS) has maintained a position of leadership in Rhinology.

The ARS is the only professional organization that deals specifically with issues of sinus surgery, both conventional and endoscopic. The ARS promotes excellence in clinical care, investigation and education in the fields of Rhinology and Sinusology. The ARS is dedicated to providing communication and fellowship to its members through ongoing continuing medical education, economic and social programs.

Why does membership make sense?

As part of its purpose, the ARS has focused intensely on the various patient advocacy problems in Rhinologic practice. The ARS explores every avenue to serve its membership as unpredictable changes in health care delivery systems continue to unfold. Most recently the ARS has helped clarify, on our behalf, the interpretation of CPT code 61795 used for stereotaxic navigation during sinus surgery. Also, when in 1993 it became apparent that HCFA's proposed revision of CPT coding would have resulted in a approximately two-thirds cut in reimbursement to physicians, the ARS engaged the services of a prominent attorney to contest the revision. The bottom line: HCFA agreed to keep the old codes in place

while reworking new ones! Our society continues to seek out methods by which it can be proactive in the very critical patient advocacy issues confronting us during the current healthcare climate.

The ARS has always been active in sponsoring major educational meetings in Rhinology. In this regard our society maintains its semi-annual, scientific meetings and offers three separate awards: The Resident Research Award, The Maurice H. Cottle Honor Award, and the Basic Science Award. Apart from its annual Fall and Spring meetings, this society has sponsored four major international symposia in the last 7 years. We are ardent supporters of resident education and have offered stipends and travel support to these meetings. With commercial support, our society is now able to issue significant research grants towards improving our understanding of diseases of the nose and paranasal sinuses.

In addition to the professional camaraderie, educational, research and socioeconomic benefits available, regular membership in the ARS also includes a subscription to the ARS newsletter which updates membership on the society's activities and a subscription to either the American Journal of Rhinology, the official publication of the Society, or the international journal - Rhinology.

In summary, changes in health care have strengthened our society's commitment and determination towards the betterment of our membership and the patients that we serve.

It has become increasingly obvious over the past nearly 20-years that the dawning of endoscopic sinus surgery in the United States was indeed the birth of a surgical discipline. Although endoscopic sinus surgery brought a dramatic reduction in the number of open procedures performed, the ingredients to lead practitioners to a mature discipline were simply not included at the onset and remain in question today. The knowledge base of the relevant precise surgical anatomy remains low. There is no unanimity as to the indications for surgery, the extent of surgery to be done or even the ideal candidate for the procedures. Further, some of the early caveats have quietly gone by the wayside. For instance, the initial recommendation to enlarge the maxillary ostium anteriorly proved to be incorrect, based on a study using fluorescein in the lacrimal system. Moreover, studies looking at complications showed no increase in percentage or severity if one operates directly off the monitor or via the endoscope.

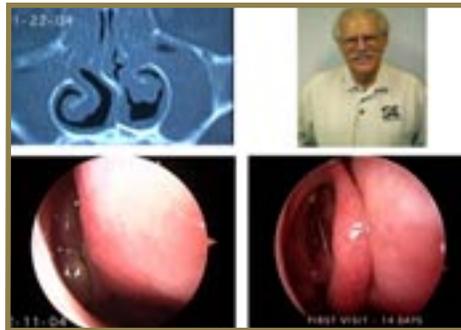
Endoscopic sinus surgery must be seen then as a surgical endeavor with insufficient guidelines and rules to qualify as anything other than a developing surgical discipline. As an example, for most surgeons a middle meatal antrostomy is a first step, although, in retrospect, studies to support the necessity of this recommended intervention were never done and remain a void in the rhinologic literature. Similarly, the teaching that patients require postoperative debridement has been presented as dogma from the beginning. Meant to serve as a continuation of the initial surgical intervention, it is reimbursable, and for most practitioners debridements are deemed critical to a successful outcome. Despite the fact that almost 20-years have yet to produce a study proving its necessity, the practice maintains a strong, and possibly unjustified, ongoing credibility.

Does wound science elsewhere in the body suggest that healing is enhanced by routine debridement of the biologic process? Was the initial recommendation because of early “grab and

tear” instrumentation and the prospect of secondary healing? If so, has the development of precision instrumentation and surgical techniques necessary to preserve the “birth membrane” obviated the need for such repeated postoperative interventions? Is the lesser healing burden bestowed on the patient with improved surgical techniques such that granulation tissue and synechia are no longer routinely clinically significant? There can be little argument that the absence of bare bone with the preservation of the patient’s own membrane, diseased or not, at the limits of the dissection obviates the necessity for secondary regeneration of a new membrane, clearly shown to be inferior in every respect.

Knowing the scenario of lining preservation and primary healing to be both desirable and feasible, can the time, travel and expense of adult “clean-outs” , which imply healing by secondary intention, any longer be justified, much less the general anesthesia requirement for pediatric patients? Wherein lies the rationale for multiple “clean-outs” being essential for adults and one debridement under general anesthesia (or perhaps none) sufficing for pediatric patients?

Absent compelling evidence of its clinical necessity, is it time to redefine a postoperative debridement as an occasionally indicated procedure rather than a routine one that is open to repeated application? Are routinely repeated postoperative debridements consistent with the concept of minimally invasive surgery and with it lining preservation? Are routine postoperative debridements perhaps a deterrent to the further advancement of minimally invasive surgical techniques? Perhaps putting routine debridements behind us is important for the maturation of endoscopic sinus surgery if it is to take its place as part of the community of minimally invasive surgical disciplines. At the very least, a study looking at surgical techniques and the respective resultant outcomes with and without debridement seems long overdue.



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As endoscopic sinus surgery has evolved over the past two decades, there have been tremendous advancements and refinements of the operative technique, facilitated by technological innovations such as mucosal sparing instrumentation, image guidance, and powered tissue dissectors. Peri-operative management has also progressed, albeit less dramatically, fueled by new pharmaceutical agents and shifting concepts of the underlying pathophysiology of rhinosinusitis. Pre-operative maximization of medical therapy, limitation of intranasal packing, and post-operative topical saline washes are examples of practices derived from the accumulated experiences of sinus surgeons suggesting a benefit in surgical outcomes. Although there have been very few studies that have addressed these issues in a scientific manner, much of the dogma associated with endoscopic sinus surgery has arguably been validated by its high rate of success. Over time, ESS has become increasingly safe and the results consistently better as practitioners incorporate new technologies and scientific discoveries into the time-proven fundamental principles.

One of the central tenets of post-operative care in ESS is that endoscopic surveillance should be performed on a regular and frequent basis in the early post-operative period. The goal of this practice is mainly to assess the status of healing in the sinonasal cavities and to guide medical therapy as necessary to control infection or persistent inflammation. In addition, nasal endoscopy provides an opportunity to debride devitalized bone, obstructing crusts, or developing synechiae that may impede proper healing or delay return of normal sinus function. To be performed successfully and properly, debridement frequently requires surgical instrumentation, additional topical or injected anesthetic, and adequate time. For this reason, debridement is justifiably a reimbursable procedure beyond and separate from nasal endoscopy. Unfortunately, the economic incentive associated with endoscopic debridement has led to exploitation of the billing code by some surgeons and, as a consequence, there have been recent calls from both within and outside the rhinology community for clarification of the term and limitation of its use. A few have even questioned whether endoscopic debridement should be performed at all as a routine aspect of post-operative care in ESS.

In the absence of case-controlled prospective studies comparing outcomes with and without debridement, the role of debridement is, in essence, a matter of philosophy and opinion, backed only by personal experience and educational bias. As with most diametrically opposed beliefs, the truth likely lies somewhere in-between the position of the “debriders” and the “non-debriders”. In cases of minimal disease, particularly when strict mucosal-sparing technique is applied, it is correct that debridement is often not necessary. On the opposite end of the spectrum, it seems clear that in cases of polypoid pan-sinusitis with inflamed and infected mucosa, or revision surgeries with existing scarring, vigilant and proactive postoperative care is required. Regardless of the degree of mucosal disease or previous surgical history, every sinus surgeon strives to be as atraumatic as possible and to have minimal, if any, debridement to

perform afterwards. That being said, imperfections do occur from time to time, and most patients develop at least some degree of crusting within the middle meatus. Although there is a theoretical case to be made that debridement in these circumstances is unnecessary and perhaps even counter-productive to healing of the sinonasal mucosa, the weight of nearly 20 years experience supports the opposite argument. Any proposed paradigm shift would need to be driven by compelling evidence that debridement is not critical to the success of ESS, rather than the other way around.

Despite the fact that the purpose of debridement is to promote healing, it is not necessarily the act of debridement that accomplishes this aim. There are often areas, especially in the frontal recess, that may be difficult to evaluate postoperatively without first removing old blood, crusts, or fibrinous debris. If the goal of postoperative endoscopy is to assess the state of sinonasal mucosa and sinus cavities, that intent cannot be met if the mucosa is obscured. Common sense dictates that debridement be performed in the postoperative period as often and to whatever extent necessary to be able to completely evaluate the sinus cavities. This does not mean that every last crust has to be pulled off, nor that every time a suction is placed in the nose that it is to be considered a debridement. The message is to be judicious with the application of the procedure and ethical about the billing. For the future, prospective outcome studies concerning the role of postoperative debridement should be encouraged, and the results critically analyzed to ultimately shape recommended practice guidelines.

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material for our scientific meetings. This will improve the efficiency of the maintenance of the records necessary for the Society to maintain its accreditation. We welcome the addition of this consultant to the Rhinology team.

Dr. Ron Cannon has some interesting material included for your review in this edition of Nose News. The Manpower issue is something we all should take home for consideration of our futures.

Thanks to all who attended the recent COSM meeting in Phoenix. Make plans now to share the past, present, and future of Rhinology by attending the 50<sup>th</sup> Anniversary Meeting of the American Rhinological Society September 18-20 in New York City.

James A. Hadley, MD, FACS  
President, American Rhinological Society



# CASE OF THE QUARTER: ENDOSCOPIC ENCEPHALOCELE REPAIR

James Palmer, MD, FARS, Ioana Schipor, MD Jonathan Cryer, MD

## CASE REPORT

A 38-year old woman presented with a history of headaches, left frontal pain, nasal congestion, and intermittent anosmia. Her past medical history was significant for obesity, hypertension, and asthma. Initial outpatient nasal endoscopy revealed a deviated septum and bilateral middle meatal edema. She was treated with a steroid dose pack, four weeks of antibiotics, and steroid nasal sprays for presumed chronic sinusitis; with continued symptoms, CT scan imaging of her sinuses was performed revealing a bony defect in the roof of the left ethmoid sinus with a soft tissue density suggesting an encephalocele (Figure 1), as well as obstruction and opacification of her left frontal sinus. An MRI scan confirmed the presence of herniated intracranial contents within the left ethmoid cavity. An incidental note was made of an empty sella (Figure 2).

The decision was made to proceed with elective surgical management. A lumbar drain was placed and 0.1 mL of 10% fluorescein diluted in 10 mL of the patient's CSF was injected intrathecally as well as frameless stereotactic computer-assisted surgical navigation system was used for localization. The encephalocele was isolated in the area of the left frontal recess, and once adequate exposure of

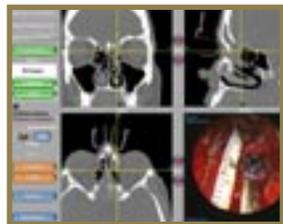


Figure 3. Intraoperative view showing skull base defect after encephalocele has been reduced

of was achieved, the lesion was fulgurated using bipolar cautery to the level of the skull base. An 8 x 6 mm bony defect with copious CSF drainage (Figure 3) was identified, and the resultant defect was repaired with a suitably shaped septal bone graft placed in the epidural space. This was followed by application of fibrin glue and a free septal mucoperichondrial graft, followed by stent in the area of the left frontal recess was then with a custom-tailored silastic sheet. The lumbar drain was maintained for two days postoperatively, with intracranial pressure was monitoring during this time and was with pressures of 20-29 cm H<sub>2</sub>O. Given our previous experience with spontaneous anterior skull base encephaloceles in the context of elevated intracranial pressure, the patient was started on acetazolamide, 500 mg, which brought intracranial pressures to the range of 13-18 cm H<sub>2</sub>O. She was discharged home on postoperative day#3; gentle debridement was performed 1 week after surgery; her frontal sinus stent was removed in the office after 2 weeks. She remains on acetazolamide four months postoperatively. On follow up, the graft remains in place, the frontal recess is widely patent, and the

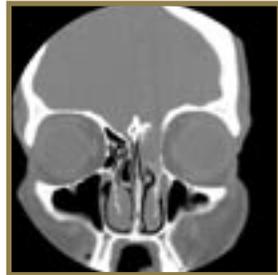


Figure 1. Preoperative CT scan showing skull base defect on the left

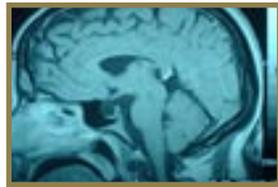


Figure 2. Preoperative MRI showing an enlarged, empty sella

mucosa is well healed (Figure 4). She is free from headache and facial pain. There is no evidence of CSF leak or recurrent encephalocele.

## DISCUSSION

This is a case of endoscopic resection of a spontaneous encephalocele with bone graft reconstruction of the skull base. Encephaloceles are defined as herniations of intracranial contents through the skull. They may contain either meninges alone (meningocele) or meninges and brain matter (meningoencephalocele). These lesions can be either congenital or acquired. The most common acquired etiology is iatrogenic following sinus surgery, with other causes being trauma, tumor, and benign intracranial hypertension. As in the case presented here, a strong association has been described between certain encephaloceles and the radiologic finding of an "empty sella."<sup>1</sup> It is postulated that, in these cases, elevated CSF pressure exerts pulsatile forces, which cause erosion of already weak regions of the skull base creating defects and, ultimately, encephaloceles.

Anterior skull base encephaloceles are usually discovered following investigation of rhinologic complaints such as nasal obstruction, sinusitis, clear rhinorrhea, or, rarely meningitis. Once identified, prompt surgical intervention is warranted given the theoretical risk of developing meningitis. Pre-operative workup begins with meticulous nasal endoscopy followed by non-contrast sinus CT scan with both axial and direct coronal cuts. Clear rhinorrhea, if present, should be collected and assayed for beta-2 transferrin. MRI is especially helpful in distinguishing between encephalocele and inspissated secretions, in identifying the contents of the sac, and the presence of significant vascularity.<sup>2</sup>

Classic treatment for encephaloceles involved neurosurgical transcranial approaches, with attendant risks, morbidities and prolonged post-operative recovery courses. External approaches have also been used, though these have the disadvantage of facial scar. In recent years, transnasal endoscopic approaches have become the standard of care. Their low morbidity and excellent success rate make them especially suitable for repair of ethmoid and sphenoid encephaloceles.<sup>3</sup> The basic tenets of endoscopic resection are wide exposure of the encephalocele and surrounding skull base via meticulous dissection, resection of the encephalocele flush with the skull base, removal of a rim of mucosa surrounding the skull base defect, and accurate fit of graft material to the defect. Choice of graft material is dictated by defect size and configuration, underlying pathophysiology, and surgeon preference. Free or pedicled mucoperichondrial grafts, fascia, composite turbinate grafts, cartilage grafts, bone grafts, and hydroxyapatite cement have all been used successfully.<sup>4</sup> While small defects are often adequately treated with pliable graft material such as mucoperiosteum or fascia, larger defects and those found in the context of benign intracranial hypertension



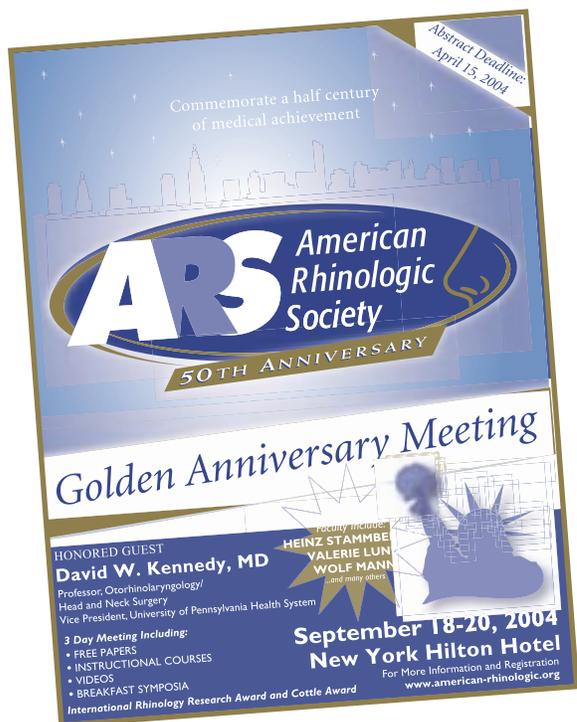
Figure 4. Postoperative endoscopic view showing a well healed cavity and a patent frontal recess

# CASE OF THE QUARTER

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probably warrant placement of an epidural bone graft<sup>5</sup>. Lumbar drains can be used intraoperatively to assist with encephalocele localization (after intrathecal administration of fluorescein) as well as to shunt CSF away from the defect, allowing easier placement of graft material. In the early post-operative period their utility lies in preventing graft-threatening spikes in intracranial pressure due to inadvertent coughing, sneezing, or emesis. The use of acetazolamide has been shown to reduce intracranial pressure via inhibition of CSF production, and is a useful adjunct in patients for whom elevated intracranial pressure is felt to be responsible for encephalocele formation<sup>6</sup>.

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2. Marshall AH, Jones NS, Robertson IJA. Endoscopic management of basal encephaloceles. *The Journal of Laryngology and Otology* 115: 545-547, 2001.
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come see us in the Big Apple...

# ARS WEB UPDATE

Martin J. Citardi, M.D, FARS, ARS Information Technology Officer

Since the late 1990's, the ARS has deployed a variety of web services that have enhanced the society's fundamental operations. The ARS web effort ([www.american-rhinologic.org](http://www.american-rhinologic.org)), developed and hosted by Wildfire Internet Services ([www.wildfireinternet.com](http://www.wildfireinternet.com)), has been deployed as a series of modules. Each module functions as a separate component within the entire framework of ARS Information Services.

In sum, these modules are as follows:

- Public Web pages (information for the general public and the medical community)
- e-Abstract Module (paperless system for abstract submission, review and web-based publication)
- e-Survey Module (Internet-based surveys of users of the ARS web site)
- Member Services (membership records, including dues administration, invoicing and payment)
- ARS Messenger (mailing system that generates messages to the membership via E-mail, fax or regular mail)
- Scientific Meeting Registration Module (on-line meeting registration for scientific events)
- Special Event Registration Module (on-line meeting registration for special events)



Of course, some of these services require the use of a member username and password. If a member is uncertain about his or her login info, he or she may select the login confirmation tool on the login page (<http://app.american-rhinologic.org/controller.jsp?ACTION=Login>).

The ARS home page ([www.american-rhinologic.org](http://www.american-rhinologic.org)) now has a list of ARS Quick Links, which provide ready access to the member-only ARS web services. Also, each web page has an icon of a key in the header. Clicking on this icon will also activate the link for the login page.

If you have any questions, please contact us at [arsinfo@american-rhinologic.org](mailto:arsinfo@american-rhinologic.org).

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Permit No. 722

### UPCOMING RHINOLOGY MEETINGS & IMPORTANT ARS DATES

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|--|--------------------|
| * Rhinosat ERS Meeting , Istanbul, Turkey  | June 1, 2004       |
| * Mount Sinai Comprehensive Sinus Surgery, Mount Sinai School of Medicine<br><i>Contact: Nicole Provonsil 212.241.7063</i> | June 7-11, 2004    |
| * Current and Advanced Techniques in FESS<br>St. Paul's Sinus Center, UBC, Vancouver, <i>Contact: Luke 604.822.6434</i>    | July 21-24, 2004   |
| * Deadline for Cottle Award Submission   | August 1, 2004     |
| * Deadline for International Rhinology Research Award  | August 7, 2004     |
| * ARS Golden Anniversary Fall Meeting, NYC   | Sept. 18-20, 2004  |
| * The Nose: Inside and Out, University of Virginia,<br><i>info at uvacme@virginia.edu</i>                                  | October 6-9, 2004  |
| * Abstracts Due, Spring Meeting  | November 1, 2004   |
| * Queen City Endoscopic Sinus Course, University of Cincinnati<br><i>Contact: Robbie 513.558.5391</i>                      | November 6-7, 2004 |
| * Membership Dues  | December 15, 2004  |

If you would like to have your upcoming rhinology meeting noted here, simply provide the editor with pertinent information: [newsletter@american-rhinologic.org](mailto: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 Rhinological Society.**

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