NOSE American Rhinologic Society NEWS

PRESIDENT'S MESSAGE

FALL 2005

Joe Jacobs, MD
ARS President

The American Rhinologic Society has completed our 51st year following the Golden Anniversary Meeting in New York City during September of 2004. The success of the New York City meeting was based upon a number of societal goals which were developed through the efforts of our past presidents and board members. These accomplishments will continue to propel our society forward over the ensuing decades. Of course, the ARS would not flourish without the enthusiastic support of each and every one of our members.

Our achievements include increased attendance, both domestic and international, at our excellent scientific meetings in the spring and fall. The number of superb abstracts submitted for consideration by the program committee is rapidly expanding which has forced the program committee to work in overdrive to complete the arduous evaluation task. Secondarily, the American Journal of Rhinology, the official publication of the ARS, continues to benefit from the science within our society. The ARS has developed an International Committee to work with the Board on international promotion of our scientific meetings as well as to increase international membership within the Society.

Our corporate supporters have continued their activity both within the educational and scientific arms of the society enabling us to award CORE grants, to enhance the format and goals of our scientific meetings, and to continue publication of the ARS newsletter which is sent to all Otolaryngologists. The entire membership is extremely grateful to all of our friends for their untiring efforts. The continuing success of our programs depends on these relationships.

The enthusiasm and activity within the society, although without doubt related to the efforts of our Board Members, has increasingly become dependent upon the activities of the many Committee Chairs and Committee members. The ARS Board asked for committee volunteers during the early months of 2005 and the response was outstanding. Each committee will require at least 1 new member every year to continue an uninterrupted work effort and continuity. Please watch for this announcement in the Newsletter and through the ARS Messenger service.

I want to personally thank each Committee Chair; Bill Bolger, Andy Lane, Martin Citardi, Peter Hwang, Stil Kountakis, Tom Tami, Mike Setzen, Paul Toffel, Todd Kingdom, Rod Lusk, Allen Seiden, Jim Palmer, and Karen Fong for their time and effort working with their committee membership on ARS projects and initiatives. The obvious result of the dedication of these individuals is the number of actual face to face committee meetings that now routinely occur prior to or just following our Board Meeting.

The ARS has a full time Administrator, Wendi Perez who has worked part time with the society over many years and is therefore extremely familiar with ARS activities and goals. She will certainly provide continuity and communication between the Executive Committee, Board and our Membership. We all welcome her to the position.

> " The ARS would not flourish without the enthusiastic support of each and every one of our members....."

The year has been a wonderful and rewarding experience for me. My thanks to all the Executive Committee and Board Members; Marvin Fried, David Kennedy, Mike Sillers, Howard Levine, Jim Hadley, Don Lanza, and Jim Stankiewicz. In addition, my office staff Kathy Bellucci and Susan Fern, my daughters Stacy and Allison as well as my wife Patti deserve special praise for their patience during a very busy year.

The American Rhinologic Society would like to thank Gyrus ENT for partnering with the ARS Newsletter for 2005

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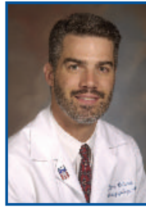
ARS MEMBER BENEFIT: THE AMERICAN JOURNAL OF RHINOLOGY

Richard Orlandi, M.D. *AJR Editorial Board*



The American Journal of Rhinology (AJR) clearly stands out as the premier journal dedicated to nasal and sinus disease and receiving this journal free of charge is a significant benefit of membership of the American Rhinologic Society.

Founded by Guy Settipane, MD over 18 years ago, the American Journal of Rhinology continues to be published by Oceanside Publications, Inc. and its editorial staff is led by David W. Kennedy, MD, Editor-in-Chief. Under Dr. Kennedy's direction, AJR's scientific content has increased in both quality and quantity. AJR is not only the leading journal in rhinology but also has evolved into one of the leading journals in the field of otolaryngology, as measured by journal impact factor (JIF). The JIF is an index of the frequency with which the journal's articles are cited and AJR's places it at a level between such other otolaryngology journals as *Annals of Otology, Rhinology, and Laryngology* and *Otolaryngology-Head and Neck Surgery*.

While the quality of the published articles remains high, the editorial board of AJR is also dealing with an increased number of submissions. In 2003, the journal moved to an electronic submission format. Found at http://ajr.msubmit.net/, the electronic submission transition was completed in 2004 and greatly facilitates the submission and evaluation of potential articles. Last year, approximately 250 original articles were submitted to the journal for publication from all parts of the world. These submissions are reviewed by at least two peers on the review panel, made up of dozens of experienced rhinologists. Like the associate editors, who manage the editorial process, the peer reviewers are volunteers who donate their time in order to further the science of rhinology.

Each year, a larger number of articles are submitted to AJR than the previous year. The editorial staff has noted an increasingly high level of scientific merit in the articles as well. In order to disseminate this ever-increasing body of rhinologic information, AJR recently expanded its number of articles per issue. This move helped somewhat but more articles of ever increasing quality continue to be submitted. The editorial board is considering additional expansion options to accommodate these submissions. However, this will involve some additional publishing expense.

AJR is the official journal of the American Rhinologic Society and is included as a membership benefit for fellows, members, and associate members of the ARS. In addition to the scientific articles, the journal contains information on upcoming rhinology meetings and information about ARS activities.

The American Journal of Rhinology is a valuable benefit to members of the American Rhinologic Society. If you are not yet a member, join today!

SUCCESSFUL LOS ANGELES FALL MEETING

Micheal Sillers, MD *President-Elect and Program Committee Chairman*

Thanks to all who attended and supported the recent American Rhinologic Society scientific meeting in Los Angeles, CA. The meeting provided an excellent complement of clinical updates as well as insights into exciting areas of research in our specialty. While slightly distracting it was encouraging to have to ask for additional seating to be placed during free papers presentations. It was standing room only!

Upcoming Events and Deadlines:

November 15, 2005
Paper/Poster Submission Deadline, ARS Spring Meeting

December 15, 2005
Deadline for Letters of Intent, ARS CORE Research Grants

January 15, 2005
Deadline for Grant Submission, ARS CORE Research Grants

May 19-20, 2006
ARS Spring Meeting, Chicago, IL

FELLOWSHIP ASSISTANCE PROGRAM (FAP) OF THE

David W. Kennedy, MD, *President of ARS*

Two years ago the American Rhinologic Society Board of Directors asked the Education Committee and its Chairman Winston Vaughan, MD to explore issues related to fellowship training in Rhinology. Beginning with a retreat in December 2003 in New York City, many aspects of fellowship training were discussed, focusing on the development of standardized application, interview, and position offer dates in order to assist candidates in their fellowship selection process. The Education Committee endorsed this concept and presented guidelines for fellowship application dates to the Board at the Spring 2004 meeting. The following dates were approved by the Board:

Interview Dates:	*March 1- June 10, 2005*
Evaluation and Ranking:	June 11-13, 2005
Offers Extended:	*June 14, 2005*
Program Start Date:	*July, 2006*

During the 2005 COSM meeting, directors and representatives from 16 US and Canadian fellowship programs met for the first time to discuss these proposals and develop a plan for immediate implementation. Though several programs had already completed the process and made offers for their 2006 positions, interest in reshaping the entire process remained high. A wide-ranging lively discussion was had, and several high priority issues identified, the most pressing of which being implementation of the newly proposed application dates for the 2006 positions. To facilitate this, an *ad hoc* committee from the ARS leadership was appointed by President Jacobs consisting of Paul Toffel, MD, Past-President of the ARS, and Brent Senior, MD, Secretary-elect of the ARS, and myself as Chairman of the Education Committee. This ad hoc group was charged with facilitating the fellowship selection process by providing blinded and unbiased selection assistance for candidates and programs (Fellowship Assistance Program or FAP) according to the previously established timetable.

On May 24, 2005 19 US and 2 Canadian programs were invited to participate in the FAP, and ultimately 9 programs agreed to participate. On June 14th, the "FAP Link" occurred between the nine programs and 10 applicants. All but 2 programs successfully linked with an applicant; 6 programs receiving their 1st choice and 1 their 2nd choice. Seven applicants successfully linked with a program; 3 receiving their 1st choice, 3 their 2nd choice, and 1 their 4th choice. One applicant, however, after linking with his 1st choice program elected to withdraw from the process entirely and not pursue fellowship training.

Overall the feedback from participating program directors and applicants was overwhelmingly positive, with the major weakness being lack of "100%" participation by training programs. FAP's objective to function as a facilitator for linking programs and applicants appears to have been met with this initial effort.

Moving forward we face several challenges. We must pursue 100% program participation and create an approach that fosters such commitment. The concept of a "binding agreement" between linked programs and applicants needs to be addressed in some fashion to protect the integrity of the process. Lastly the fellowship program database needs to be refined and the next cycle of interview and application dates must be established. In order to further address these issues and others with regard to Rhinology fellowship training, a *Fellowship Committee* composed of one representative from each fellowship program in the US and Canada has been established. Working subcommittees of the Fellowship Committee have been created to address these last two issues and will deliver reports at the next meeting scheduled for September 23rd in Los Angeles. -

cont. from pg 2, SUCCESSFUL LOS ANGELES...

The 2nd annual David Kennedy lecture was given by Professor Aldo Stamm. His presentation of extended transnasal endoscopic surgery of the anterior, posterior, and middle cranial fossa was absolutely amazing. It was a testimony to Professor Stamm's skill as well as to our specialty for advancing minimally invasive surgical treatment beyond the paranasal sinuses.

Under the leadership of Dr. Jan Gosepath from Mainz, Germany, the International Committee sponsored a panel on frontal sinus surgery. PJ Wormold (Adelaide, Australia) and Aldo Stamm (Sao Paulo, Brazil) discussed anatomical considerations and surgical techniques in treating patients with frontal sinus disease. This was extremely well done and very practical in its application.

Each fall, the ARS recognizes two papers for excellence. Congratulations to the following individuals for their outstanding papers:

Cottle Award Winner:

Acoustic Rhinometry Predicts Tolerance of Nasal Continuous Positive Airway Pressure (nCPAP): A Pilot Study

Luc G. Morris, MD, Jennifer Setlur, BS, Omar E. Burschtin, MD, David L. Steward, MD, Joseph B. Jacobs, MD, Kelvin C. Lee, MD

International Research Award

Brain Perfusion SPECT Findings in Patients with Posttraumatic Anosmia and Comparison with Radiologic Imaging

Mohammad Eftekhari, MD, Majid Assadi, MD, Majid Kazemi, MD, Mohsen Naraghi, MD, Jalal Mehdizadeh, MD Mohsen Saghari, MD, Alireza Mojtahedi, MD, Mohammad Sadeghi-Hasamabadi, MD, Armagan Fard-Esfahani, MD, Babak Fallahi, MD, Davood Beiki, MD

cont. on pg. 7

AMERICAN RHINOLOGIC SOCIETY – CORPORATE AFFILIATES PROGRAM

Paul H. Toffel, MD, *Committee Chairman*

It is with great pride and affection that I review the Corporate Affiliates program of the American Rhinologic Society because it parallels the wonderful growth and spirit of our organization since the mid-90's.

The idea for corporate friends of our society to sponsor pure unrestricted research grants in Rhinology was seeded by our devoted Treasurer, Dr. David Kennedy, in 1995, during the tenure of President Vijay Anand. At the winter board meeting in New York City that year, our Board of Directors discussed and formed this new initiative, which has brought approximately $400,000 to our young faculty investigators and residents in the form of $25,000 and $8,000 annual grants.

Through the presidential terms of Drs. Dale Rice, Mike Benninger, Bill Panje, Charlie Gross, Fred Kuhn, myself, Don Lanza, Jim Hadley and Joe Jacobs, this program has allowed over two dozen of our young, bright minds to have unfettered funds for direct basic science research in all aspects of Rhinology.

The program has been elevated by its administration via the CORE (Combined Otolaryngologic Research Entity) initiative of our affiliated umbrella societies, and the ARS can be proud of awarding approximately 10% of all research dollars granted via CORE the past decade.

None of this would be possible without the synergies we have with our wonderful instrument and pharmaceutical corporate thought-leaders who recognize the value of working with our society's research arm with no restrictions upon our use of the funds. We have fostered wonderful relationships between industry and our society for the greater good of our rhinology patients.

The research programs continue to gain support from our corporate affiliates, who have the opportunity to meet with our society's thought-leaders at functions we sponsor for the corporate friends each year at our spring meeting.

The society is always grateful for educational grants from industry which help our endeavors, and these are always recognized in our meetings and publications, but we are particularly grateful to these corporate affiliates who place pure research for the benefit of our medical and surgical patients foremost. It has continually been an honor for me to serve the society as Chairman of this Committee, and I'm always helped by all the members who suggest contacts to foster these lofty goals. -

ARS Resident Research Grant
$8,000 for one year

ARS New Investigator Award
$25,000 for up to two years

New for 2006

SAHP/AAOA/AAO-HNSF/ARS Surgeon Scientist Career Development Award
$100,000 **This is a one-time solicitation for one non-renewable project.

Deadlines
On-line Letter of Intent: December 15, 2005
On-line Application: January 15, 2006

For more information
http://www.entlink.org/research/grant/Foundation-Funding-Opportunities.cfm

2005 ARS CORPORATE AFFILIATE RESEARCH GRANT PROGRAM PARTICIPANTS

Platinum ($10,000)

Aventis
Gyrus ENT

Gold ($5,000)

Karl Storz Endoscopy America
Abbott Laboratories
Naryx Pharma, Inc.

Silver ($2,500)

Medtronic-Xomed

Bronze ($1,000)

GE Medical Systems Navigation & Visualization

Richard Wolf Medical Instruments Corp.

CASE OF THE QUARTER: MULTIPLE MUCOCELES

Spencer C. Payne, MD and Mark A. Zacharek, MD

This is a 42 year old man with a past medical history significant for seasonal allergic rhinitis who presented with complaints of intermittent left eye and forehead swelling over the preceding two months. He had originally presented to his primary care provider three months previously with left facial pain and pressure and discolored nasal discharge. He was diagnosed with acute sinusitis and prescribed a course of amoxicillin. Though his episode of sinusitis resolved, he returned for evaluation one month later with complaints of left eyelid swelling. Despite improvement with antibiotics, he returned twice more with continued complaints of intermittent recurrence of this swelling which would resolve with antibiotic therapy. Eventually a computed tomography (CT) scan was obtained (Figures 1 and 2) which revealed large frontal and maxillary sinus mucoceles with erosion of the frontal sinus into the orbit. He was then referred to the rhinology service.

On physical examination he was found to have obvious left periorbital ecchymosis and edema. Proptosis and upward gaze limitation was noted and ophthalmologic exam confirmed myopia unchanged from baseline. Endoscopic examination of the nasal cavity revealed leftward septal deviation with boggy edema of the middle turbinate and middle meatus. Individual middle meatal structures could not be discerned.

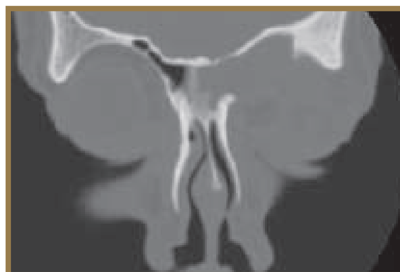


Figure 1

Coronal CT scan showing orbital erosion and neo-osteoneogenesis of the frontal recess

The patient was taken to the operating room where an endoscopic septoplasty was performed in order to facilitate access to the middle meatus. The uncinate was found to be displaced medially and after it was taken down with powered instrumentation; a maxillary antrostomy and anterior ethmoidectomy were completed. Due to significant edema and bleeding, however, the frontal recess was unable to be accessed endoscopically and the decision was made to perform a mini-trephination.

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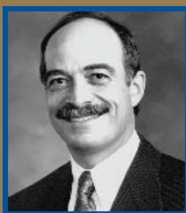
PATIENT ADVOCACY CORNER



CMS DENIES COVERAGE OF +61795 IN AN ASC SETTING

Michael Setzen, MD, FACS, *Chair, Patient Advocacy Committee*

Well, good news and bad news on the interim rule for ASC covered services.

Good news: 31233, 31235, 31237, and 31238 will NOT be deleted from the ASC list. Medicare has accepted our arguments that removing these would cause harm to beneficiaries who may need the additional services rendered in a facility.

Bad news: they did not accept our position on +61795. They said that this CPT code was for coding the use of equipment, not a surgical procedure, and therefore was not appropriate for the ASC list.

The interim final rule was published in the Federal Register on May 4. We had 60 days from that date to comment but both the ARS and AAO-HNS Boards elected not to challenge this denial in spite of their disapproval. There was concern that in so doing one might irritate CMS and they may request a review of other FESS Codes. Furthermore they did include the Physician Component of reimbursement for +61795 .

Many Carriers in different states around the country are challenging Otolaryngologists with respect to Evidenced based need for IGS.

It has been suggested when challenged that you meet with the involved Carrier and present the Academy's Guidelines for the use of IGS.

It is suggested that you respond as follows when questioned about Evidenced Based documentation for IGS:

In general, there is mostly expert opinion, namely Level 5 evidence, demonstrating that IGS makes FESS "safer." In order to prove it is safer with level I or grade A evidence, we would need to perform a randomized study placing half of the patients in the IGS group and the other half in the non-IGS group and see who has more complications. Given the low occurrence of serious complications (less than 1%), this would require tens of thousands of patients to be enrolled to demonstrate any difference between the groups. This is a practical impossibility for two reasons:

1. Can't do a study like this enrolling >30,000 patients.
2. Ethical considerations—would you be willing to serve as a surgeon (or a patient) in such a study based on our current experience with IGS?

Another great analogy applies to **parachute** use. There is no Evidenced Based Documentation to prove that one does better with or without a parachute when jumping out of a plane because no study would subject half the jumpers to this randomized trial and so it is with IGS.

cont. from pg. 5

A small medial incision was made just over the superior aspect of the brow and dissection verified superior orbital bony rim dehiscence as seen on CT. The mucocele was sharply opened, the cavity was copiously irrigated with sterile saline, and a small drain was placed. The patient was treated post-operatively with amoxicillin/clavulanate. On follow-up evaluation the patient remained asymptomatic. Endoscopic examination revealed continued patency of the maxillary antrostomy and a probe was easily placed through a medial tract into the frontal sinus. Additionally, the trephination scar was nearly imperceptible.

Discussion

Mucoceles are most commonly frontal or frontoethmoid in origin with maxillary sinus mucoceles accounting for 10% or less.[1] Often resulting from trauma or ostial obstruction, mucoceles often expand gradually, but their progression can be much more rapid during episodes of infection. Frequently, the surrounding bone demonstrates either thickening as a result of osteitis from chronic inflammation or remodeling with resorption secondary to the chronic expansile forces and osteolytic enzymes.[2]

Since the 1980's, endoscopic management of paranasal mucoceles has become increasingly accepted[1,2,3,4] and may be the most common method of treatment currently. The specific methods or extent of surgery utilized to marsupialize the mucocele is still debated, but various series have demonstrated recurrence rates ranging from 0-13%.1-4

In the absence of trauma or prior surgery, the etiology of a mucocele may not be clear. This patient's disease was most likely a multi-factorial process. Significant deviation of the septum resulted in lateralization of the middle turbinate with osteomeatal complex (OMC) obstruction. This was further exacerbated by the patient's allergic rhinitis and his disease culminated with an episode of acute sinusitis which ultimately accelerated the process. Neo-osteogenesis, as demonstrated on CT scan, also played a part in the frontal recess obstruction. Since the infundibulum often serves as the common drainage point for the maxillary, frontal and anterior ethmoid cells it is uncertain whether the mucoceles developed simultaneous or if one played a role in the other's development. In either case, the orbital extension with erosion through the superior orbital rim complicated the situation. Even after treatment with steroids and antibiotics, the edema and bleeding encountered intraoperatively necessitated a combined external approach in order to decompress the mucopyocele and treat the infection.

> " In the absence of trauma or prior surgery, the etiology of a mucocele may not be clear....."

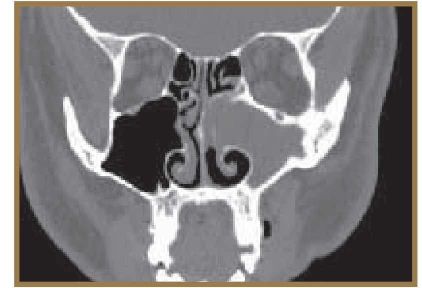


Figure 2

Coronal CT scan showing expansile changes of the maxillary sinus mucocele

In the patient that does require additional surgery to manage frontal disease, the use of a mini-trephination may be first recommended in combination with endoscopic frontal sinusotomy as it has provided encouraging results and often obviated more extensive procedures such as osteoplastic flap and obliteration.[5] In this instance, the trephination provided a good result. When addressing complicated or large frontal mucoceles, other authors have also advocated for more aggressive management such as an endoscopic Lothrop procedure (Draf III).[4] Had this patient needed additional procedures and visualization of the frontal recess and nasofrontal cannulation continued to be difficult, an endoscopic transseptal frontal sinusotomy may also have been appropriate. With this approach, assisted by image guidance, a small perforation of the septum would be created at the septal attachment to the skull base allowing for better exposure, sinus drainage and post-operative evaluation and management.[6]

The endoscopic management of paranasal sinus mucoceles in combination with more conservative external procedures, such as the mini-trephination, has become an accepted surgical option. These approaches can be initially attempted in order to avoid the complications that may accompany more extensive operations. Medical therapy and optimal management of the etiologic factors should also be employed to minimize disease recurrence.

[1] Busaba N, Salman SD. Maxillary sinus mucoceles: Clinical presentation and long-term results of endscopic surgical treatment. Laryngoscope. 1999;109:1446-9.

[2] Benninger MS, Marks S. The endoscopic management of sphenoid and ethmoid mucoceles with orbital and intranasal extension. Rhinology. 1995;33:157-61.

[3] Kennedy DW, Josephson JS, Zinreich SJ et al. Endoscopic sinus surgery for mucoceles: a viable alternative. Laryngoscope. 1989;99:885-90.

[4] Har-El, G. Endoscopic management of 108 sinus mucoceles. Laryngoscope. 2001;111:2131-4.

[5] Gallagher RM, Gross CW. The role of mini-trephination in the management of frontal sinusitis. Am J Rhinology. 1999;13:289-293.

[6] McLaughlin RB, Hwang PH, Lanza DC. Endoscopic trans-septal frontal sinusotomy: The rationale and results of an alternative technique. 1999;13:279-287.

MAINTENANCE OF CERTIFICATION PROCESS AND PROCEDURES

James A. Hadley, MD, FACS Immediate Past President, ARS Director, American Board of Otolaryngology

As a Director for the American Board of Otolaryngology, I have been offered the opportunity to update the Membership of the American Rhinologic Society regarding the Maintenance of Certification (MOC) process. Beginning in 2002, the American Board of Otolaryngology (ABOto) issued ten year limited certificates for those candidates who passed the ABOto certifying examination.

The reason for the time-limited certificates is based on the recommendations of the American Board of Medical Specialists (ABMS): "In recognition of the pace of change in medical knowledge, certificates awarded more recently are time-limited, and are valid for six to ten years, at which point the diplomate must become 'recertified' through a process of continuing education in the specialty, review of credentials and further examination. Diplomates whose certificates were not time-limited when they were awarded are not required to undergo this recertification process to continue being listed as a certified specialist."

With regard to certification, the ABMS states, "The certification process is designed to assure the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality patient care in that specialty." This process is analogous to the Federal Aviation Administration. Just as pilots are federally mandated to participate in training on flight simulators on a regular basis to maintain their skills, physicians are being asked to complete competency reviews that may eventually become recognized by hospital credentialing committees.

The ABMS has initiated a process of four components that are required to be fulfilled by each applicant: 1. Professional Standing, 2. Lifelong Learning and Self Assessment, 3. Cognitive Expertise, and 4. Evaluation of Performance in Practice. These four components of the maintenance of certification process are the responsibility of each individual specialty Board, and the ABOto has recently submitted its requirements to the ABMS. Most current and future applicants to the MOC process will easily fulfill the first two components.

1. Professional Standing requires an unrestricted license and a valid ABOto certificate as well as hospital privileges.

2. Lifelong Learning requires us to complete 100 hours of CME every two years, some of which will be in interactive self-assessment programs.

3. Cognitive Expertise will be based on passing a required core examination of fundamental knowledge in addition to a specific module of specialization.

4. Evaluation of Performance in Practice will assess both Process Measures of the applicant's own patients via feedback and Outcome Measures submitted to an outside source to assist in this evaluation in practice.

The American Rhinologic Society has a unique opportunity to partner with the ABOto in the development of the modules for lifelong learning. These modules would be constructed with the assistance of the members of the ABOto Board and Senior Examiners. Each written module, for example Rhinology, will assess the clinical competency of the candidate by posing newly created questions for both the initial and revalidation examinations. Ultimately, all of the members of the ARS will benefit from the opportunity to partner with the ABOto in this development as the Society can assure the competency of its members. Implementation of these lifelong learning and self assessment modules will begin in the next year in order for the current certificate holders to begin their process in a timely fashion.

Note that the maintenance of certification process will also be encouraged by all members who do not have the time limitation on their board certificates as well. This will assure to the public that the physician is active in the educational process.

cont. from pg 3, SUCCESSFUL LOS ANGELES...

The ARS also recognizes excellence among the growing number of poster presentations. Congratulations to the following authors for their first place poster award:

Recent Advances in Mucosal Immunology and Genetics: Implications for the Pathophysiology of Chronic Rhinosinusitis
Robert C. Kern, M.D.

Finally, I would like to offer a special thanks to the members of the Program Committee who scored nearly eighty abstracts, reviewed multiple program drafts, and moderated during the free paper session. Without their input, the meeting would not have been successful. Thanks again to all who participated in our fall meeting. Without the active involvement of its members, the ARS would not be able to continue its growth and commitment to excellence. Please note the upcoming November 15 deadline for abstract submission for our spring meeting to be held in Chicago. We look forward to seeing you there!

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UPCOMING RHINOLOGY MEETINGS

Penn International Rhinology Course, — March 9-11, 2006
Advances in Management of Sinonasal Disease
University of Pennsylvania, Philadelphia, Pennsylvania
Contact: Bonnie Rosen, phone: 215.662.2137 bonnie.rosen@uphs.penn.edu

5th Annual New York Rhinology Update — April 21 - 23, 2006
New York University & Albert Einstein College of Medicine
New York City, New York, www.med.nyu.edu/cme

Southern States Rhinology Course — April 27-29, 2006
Medical University of South Carolina, Charleston, South Carolina
Contact: Carol Ellerbee, phone: 843.792.7165 ellerbc@musc.edu

Western States Rhinology Course — October 26-28, 2006
University of Colorado, University of Utah, & Stanford University; Sonoma, California
Contact: Susan Morrison, phone: 303.372.9050

27th International Symposium of Infection & Allergy of the Nose (ISIAN) — June 15-16, 2008
Crete, Greece
www.frei.gr

If you would like to 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 Rhinological Society.

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