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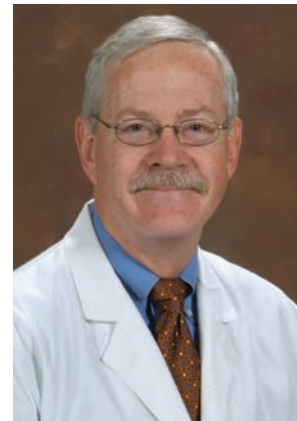
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President's Message

by: Dr. Gregory Postma, MD

2012 has proven itself to be a year of many surprises and challenges. Our recent National election ensures that the Patient Protection and Affordable Care Act and ongoing expansion of meaningful use will increasingly involve our profession. Your Georgia Society of Otolaryngology-Head and Neck Surgery (GSO-HNS) will continue to be your voice as well as a resource for all the otolaryngologists in our state. In our rapidly changing profession it is imperative that we all work together to protect the rights of our patients and I would encourage each and every otolaryngologist to be an active member in our society. In addition, I would ask that all of our members contact other otolaryngologists in their city or region to let them know about GSO-HNS.



This past year was a very active one with two well-attended meetings. Our immediate Past-President, Dr. Art Torsiglieri, ran a simply fantastic annual summer meeting at the Lowe's Resort in Orlando, Florida. This was very well received and numerous families were present to enjoy all of the great activities available in Orlando particularly Universal Studios. Our keynote speakers included Dr. Peter Belafsky of UC Davis who reviewed dysphagia and laryngology, Dr. Donald Lanza who spoke to us on complex rhinologic concerns and Dr. Larry Dinardo from Virginia Commonwealth University who updated us on Head and Neck Cancer. Our second CME activity of 2012 recently was conducted in Atlanta and the keynote speaker of this fall meeting was Dr. Blake Simpson from University of Texas, San Antonio who discussed contemporary management of airway stenosis and gave the most interesting lecture of the meeting oddly enough on mucus. This meeting was once again a joint venture with the Georgia Neurosurgical Society and was preceded the day before by the always popular Zupko coding workshop. As we enter the New Year, our next two meetings will be very exciting. Our summer gathering will be at the Ponte Vedra Inn and Club in Ponte Vedra, Florida July 18-21, 2013. One of the key areas our guest speakers will be discussing will be ways to decrease cognitive decision-making errors and systematic errors as surgeons. This will also encompass human-computer relationships as it pertains to electronic medical records and quality measures. In addition we will have the usual outstanding potpourri of clinical lectures as well as a bit of golf. Next year's fall meeting will return to the Ritz-Carlton Resort at Lake Oconee on December 6-8, 2013. The 2011 fall meeting was the first to utilize this venue and it received the best reviews of any recent fall meeting. In view of this, the Board decided to return there and we hope to have an even more outstanding meeting.

On the legislative front, your society is leading the nation in actively resisting an additional certification of competence in Pediatric Otolaryngology. This effort is spearheaded by Drs. Peter Abramson and Pablo Stolovitzky. Your Society composed a letter based on a vote of the membership at the summer meeting opposing this initiative and this statement gathered a great deal of national momentum at the recent AAO-HNS Board of Governors meeting. The initiative is currently going back under review and will now include various AAO membership surveys developed by the Academy. This proposal has extraordinary potential for unintended consequences related to access of care for children and appropriate and prompt treatment of pediatric otolaryngologic disorders. Our thanks to Drs. Abramson and Stolovitzky for leading the charge in this area. Please remember that the GSO-HNS is your state society and we are here to serve both your interests and most importantly those of your patients.

Finally please join me in congratulating Dr. Billy Silver who is our new Medical Association of Georgia (MAG) President. Billy is the first otolaryngologist to hold this prestigious position.

Please feel free to contact me or any of the Association Board Members if you have any questions or concerns related to the Association itself or our upcoming meetings.

In closing, I am honored to be your President and I look forward to seeing you at Ponte Vedra this summer.

Winter 2013

GOVERNOR'S REPORT

As many of you know, the decades old discussion on whether there should be subcertification in pediatric Otolaryngology has resurfaced and gained substantial momentum over the last couple of years. The American Society of Pediatric Otolaryngology (ASPO) feels strongly that subcertification will allow for better control of the quality of the fellowship programs. There is expectation that a request for a subcertification in advanced pediatric otolaryngology will be submitted to the American Board of Otolaryngology (ABO) within the next year. Concerned about the potential unintended consequences for patients and practicing general otolaryngologists, the board of directors of the Georgia Society of Otolaryngology submitted a resolution to the Academy Board of Governors (BOG) in opposition to pediatric subcertification. Georgia's resolution was presented at the fall academy meeting and ultimately went through the socioeconomic and grassroots committee. The resolution was amended to mandate that a poll of the member societies be undertaken to gauge the opinion of the members of the societies. The resolution, as amended, passed unanimously at the BOG general assembly. The poll, which will include statements on both sides of this issue, will be distributed to member societies in the month of January. The poll will simply ask the question: Do you agree or disagree with the proposal to have subcertification in advanced pediatric otolaryngology?



Members of the Georgia State Society should be exceedingly proud. The actions of the GSO have set off a national debate on subcertification in pediatric otolaryngology. Members of all societies will now be able to voice their opinion on whether this is in the best interest of patients and our specialty. The results of the poll will be presented to ASPO, ABO and at the spring BOG meeting.

Speaking of the spring BOG meeting, please make plans to attend this important meeting that is held in conjunction with the otolaryngology advocacy conference. The meeting will be held May 5-7 in Alexandria, Virginia. For more information, the link is: Entnet.org/bog&summit Place the website link all on one line-thanks.

Peter J. Abramson, MD

Chair-Elect, Board of Governors, American Academy of Otolaryngology

Georgia Health Sciences University

Update: *David Terris, MD*



Decade of growth

This marks the completion of our first decade as a department, and what a decade it has been. We recently added the 13th and 14th faculty members to our staff. Sarah Mowry was the student body president and a Phi Beta Kappa graduate of Earlham College, and

vice president of AOA at Tulane Medical School (see photograph). She completed her residency at UCLA and a two-year otology/neurotology fellowship at the University of Iowa. In September, she became our second Otologist/Neurotologist. George Harris joins an already busy Pediatric program. He graduated with distinction from the University of Illinois and attended Loyola University School of Medicine. He completed his residency at the University of Iowa, which included a two-year NIH-T32 funded research fellowship, and did his pediatric fellowship in Charleston. Both of these faculty members are off to a fast start, and Dr. Harris has already made a television appearance (see photograph).

In another area of growth, we are proud to report that we have recently added our 5th fellowship program. Arturo Solares directs the newly offered fellowship in Head and Neck Oncologic Surgery. Dr. Solares also recently conducted another successful international Skull Base symposium (see photograph), providing our residents with exposure to not only advance skull base surgical techniques, but also to other cultures.

As a result of our rapid growth, we now have 4 programs with national and international recognition (endocrine surgery, laryngology/dysphagia, skull base surgery, and rhinology-sinus surgery). An additional 3 programs enjoy regional acclaim (head and neck oncologic surgery, otology-neurotology, and pediatric otolaryngology).

Faculty highlights include Greg Postma completing his tenure as President of the ABEA, and beginning his term as President of the Georgia

Society of Otolaryngology; Stil Kountakis completed his term as Chair of the Practice Group at GHSU; Jimmy Brown was elected Secretary of the Georgia Society of Otolaryngology; Dave Terris was named to the Residency Review Committee – the first Otolaryngologist from Georgia ever to have this honor. Five faculty members occupy a total of 13 editorial board seats on otolaryngology journals (Kountakis, Postma, Terris, Paul Weinberger and Jimmy Brown), and three faculty members serve (or have served) as Board examiners (Brown, Kountakis, and Terris).

In short, it has been a tremendous decade, and we look forward to the next 10 years with equal enthusiasm and optimism.



Sarah Mowry became GHSU's second Otologist/Neurotologist



George Harris appears on TV; he is GHSU's second Pediatric otolaryngologist



Participants at Arturo Solares' International Skull Base Symposium

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CASE REPORT

Dr. Jimmy Brown, MD, DDS, FACS



Trans-Oral Submandibular Gland Excision: the province of the Otolaryngologist, Head and Neck Surgeon. Jimmy J. Brown, MD, DDS, FACS. Professor Otolaryngology / Head and neck surgery. Georgia Health Sciences University Claude F Harbarger, MD. Georgia Health Sciences University

Avoiding a potentially unsightly scar in the neck has been a strong motivating factor for patients and doctors to seek minimally invasive approaches to surgery in the head and neck. The ability of otolaryngologists to perform minimal access, remote access or cosmetic approaches to the thyroid and parotid glands have grown significantly in the last decade. This advancement has lagged behind for the submandibular glands (SMG). Save for a few enterprising otolaryngologists, the SMG are addressed surgically via the standard inveterate neck incision practiced for decades; one size fits all. Best practice is to offer the various options where indicated, especially to those patients with an increased risk for keloid formation. In discussions with otolaryngology colleagues who utilize the standard neck incision, lack of familiarity with the anatomical “view from above,” has been cited as a deterrent to the trans-oral approach and presents a major paradigm shift. The indications for SMG removal include: sialolithiasis, sialoadenitis, ranula, drooling and neoplasms. Specific to the trans-oral route are patient’s desire, for improved cosmesis and at risk patients for keloid formation. Contraindications for this approach would include malignant lesions and a surgeon’s lack of familiarity with the procedure.

Otolaryngologists are uniquely trained to negotiate the intricate anatomy of the head and neck region. It is not unreasonable then for us to use our knowledge and expertise intrinsic to a trans-oral approach and to offer this to our patients.

Case Report

A 42-year old male presented with intermittent left upper neck discomfort for 3 years. He notes recurrent pain which was sometimes “dull and aching,” worse when eating or with the thought of eating. On occasion he notes “sour taste in his mouth after a big yawn.” The patient had been treated

with at least three courses of antibiotics over a two-year period. Examination revealed a healthy appearing gentleman in mild to moderate distress secondary to pain in the left submandibular triangle. He had a barely perceptible fullness in the region of the SMG that was firm and tender to palpation. He had a normal mouth opening to 51mm at the incisal edges and, his dentition and gingiva appeared in fair repair. Orange colored impissated saliva was expressed from the left SMG.

CT imaging revealed a moderately enlarged left SMG with a hilar stone (Figure 1). There were no significant lymphadenopathy or other masses.

Technique of Trans-oral Submandibular Gland Excision

After appropriate preparations were made, including informed consent for a possible trans-cervical route of access and, a request for anesthesia to perform a nasal intubation, a trans-oral resection of the left SMG was successfully executed. The procedure could also be performed with the patient orally intubated as well.

The technique includes placing an adult size bite block on the contralateral side to prop the mouth open. This is followed by Hibiclen preparation of the oral cavity and cannulation of Wharton’s duct using a 22G angiocatheter that is secured circumferentially with a 2-0 silk ligature (Figure 2). This allows for expedient identification of Wharton’s duct in the surgical field during dissection proximal to the lingual nerve. The areas around Wharton’s duct orifice and on either side of the lingual

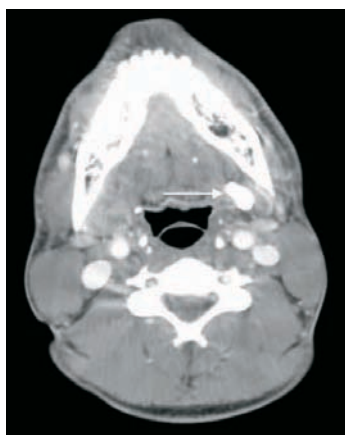
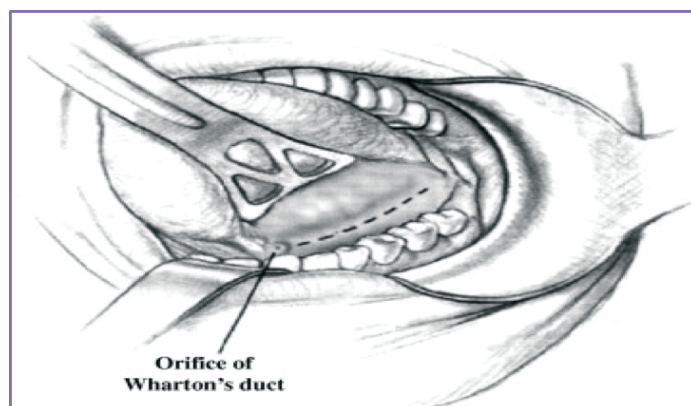


Figure 1

caruncle are injected with local anesthetic with epinephrine, extending posteriorly towards the retromolar area. The entire floor of mouth (FOM) is exposed using a combination of the Weider retractor on the lateral surface of the tongue, and or Minnesota retractors. An incision is then made through mucosa only, with a needle point cautery, encircling the duct orifice and extending in a linear fashion on either side on the lingual caruncle, to the retromolar region (Figure 3). Using a Kitner mounted on a long clamp, the mucosa can be elevated from the FOM towards the tongue superiorly and, inferiorly deep into the FOM. This will expose the sublingual gland in its entirety. Remembering that the sublingual gland is located immediately below mucosa, some parts of the dissection will need to proceed sharply to free the micoso from the sublingual gland. It is not mandatory but offers a better view if sublingual gland is removed in its entirety, using mostly blunt dissection. Be careful not to include Wharton’s duct with the gland. If the sublingual gland is attached to

Dr. Brown - Case Report continued from page 5**Figure 2**

Wharton's duct, then separate them before delivering the sublingual gland. Once the sublingual gland is removed Wharton's Duct and the lingual nerve's relationship can be appreciated. Carefully separate the duct from the lingual nerve by tunneling it beneath the nerve. Next, expose the posterior aspect of the field and follow the duct to its hilar attachment to the deep lobe of the submandibular gland. Located just below the lingual nerve and above the deep lobe is the submandibular ganglion, which should be separated from the deep lobe with sharp dissection, followed by suture ligation of the ganglionic branches of the nerve. This will allow the lingual nerve to be retracted free from the immediate surgical field. The Weider retractor should be used to capture the nerve and retract it out of the surgical field medially, along with the tongue. At this point the posterior free border of mylohyoid muscle should be identified and retracted in an anterior lateral direction using a vein retractor. With an assistant applying strong digital pressure externally from beneath the submandibular triangle, the gland will be pushed into the surgical field (Figure 4). The needle point cautery can now be used in conjunction with blunt dissection with a Kitner, to free the gland from its attachments. Start posteriorly and then move medially with blunt dissection only, then work

**Figure 3**

anteriorly and laterally with a combination of electrocautery and blunt dissection. More blunt dissection than cautery should be applied when freeing the lateral aspect of the gland to avoid injury to the marginal branch of VII. The surgeon should be prepared for control of the facial artery even though traction on the gland usually separate the main vessel from the gland, save for small bridging vessels which can be cauterized without ligature control(1). Once the submandibular gland is delivered (Figure 5) the surgical field is irrigated copiously and examined with bimanual palpation for any residual gland. The wound is then closed with 3-0 chromic suture, running or interrupted, without drains. A Barton dressing or Veronique support dressing should be utilized to support the wound and jaw. This will markedly reduce pain and swelling. Most patients can be sent home on a liquid to soft diet as well as pain medication and the surgeon's choice of antibiotics.

Discussion

Removal of the submandibular salivary gland is achieved principally via a trans-cervical approach. Most head and neck surgeons are quite comfortable with this approach which is one reason for the relative lack of enthusiasm for a trans-oral technique. The fear of loss of control of the facial artery within the restricted area of the oral cavity is another concern. Anatomical studies have demonstrated the facial artery is not encased within the submandibular gland. In fact

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it can easily be unearthed from its grove on the posteromedial aspect by gentle traction on the gland towards the surgeon during its excision (Figure 6). Small branches from the main vessels do penetrate the gland and are easily controlled with bipolar or harmonic device.

Though complications occur infrequently when the trans-cervical route is employed, the literature supports trans-oral as the safer route for this operation (2). One problem is the potential for the formation of an unsightly scar in the neck, which, in some patients may be devastating. The trans-oral route does eliminate this risk. Injury to cranial nerves is also another major pitfall of the trans-cervical route. The most commonly injured nerve associated with the trans-cervical route is the marginal branch of cranial nerve VII, which has been reported to occur in 1 to 7.7% in case series. Some reports suggest however, that this number may be grossly under reported. Other nerve injuries of note are the lingual and hypoglossal which are affected in 1.4 and 2.9 % respectively (3-4). It is important to note that upwards of 80% patients will have symptoms related to the manipulation of the lingual nerve when the trans-oral route is utilized. These symptoms are invariably transient in close

to 100% of cases (5). Another concern related to the trans-cervical approach is the difficulty in removing the entire duct from this access. Reports have shown that up to 7.4 % of subjects develop recurrent mucocoeles or stones from residual Wharton's duct remnant (6-7). This is avoided in the trans-oral route since the duct is removed in total. Therefore, removal of the SMG via the trans-oral route may ameliorate the risk of nerve injury, eliminate the chance of an unsightly neck scar and decrease the chance for recurrent mucocoeles or stone formation.

Conclusion

Improving the outcomes of our patients with benign conditions of the SMG should be our main focus. Having the options for procedures that will achieve this speaks to our "best practices" goals. The Otolaryngologist, head and neck surgeon by virtue of his or her training is uniquely positioned to provide this.

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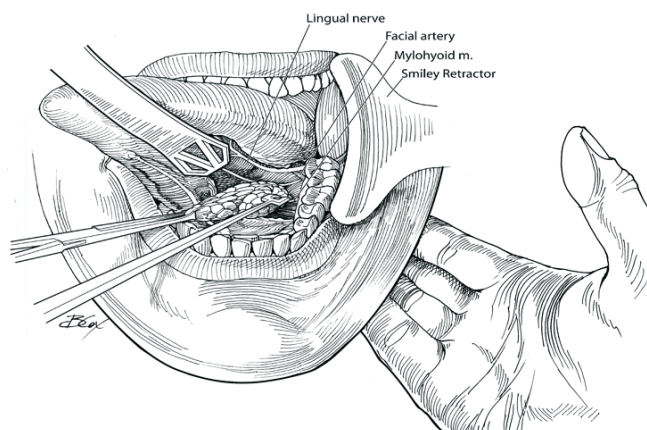


Figure 4



Figure 5



Figure 6

EMORY UPDATE:

*by: John M. DelGaudio, MD
Professor and Vice Chair
Otolaryngology-
Head and Neck Surgery*



In August the Emory University Department of Otolaryngology completed a move of the entire department from the Clifton Road campus to Emory University Hospital Midtown (EUHM, formerly Crawford Long Hospital). This move was over a year in the making, and moves

the entire department into state-of-the art clinical facilities for each subspecialty, while bringing the entire department under a single roof.

The outpatient clinical space is located on the 9th floor of the Medical Office Tower (MOT) and encompasses approximately 13,500 square foot of space. The Emory Sinus, Nasal, and Allergy Center, The Emory Voice Center, The Divisions of Otology/Neurotology and Audiology, and The Divisions of Head and Neck and Endocrine Surgery all have separate dedicated subspecialty clinical space. The Emory Sinus, Nasal and Allergy Center has 6 rhinology exam rooms equipped with High-Definition video, and 2 dedicated allergy rooms for testing and allergy shots, with an allergy sub-waiting room. The Emory Voice Center has 5 exam/procedure rooms and 3 voice therapy rooms, including a studio for care of the professional voice. The Division of Otology and Neurotology has 5 exam rooms, 3 audiology booths, and full vestibular testing and rehabilitation facilities imbedded into the clinic space. Head and Neck and Endocrine Surgery have 8 exam and treatment rooms, with imbedded speech and language pathology diag-

nostic and treatment rooms dedicated to the Head and Neck cancer patients. A unique feature of our new clinic space is the inclusion of a Head and Neck Radiology reading room within the Otolaryngology clinic space. The Radiology facility is staffed during clinic hours by faculty and fellows of the Division of Head and Neck Radiology. This provides an innovative design that allows immediate face-to-face consultation between the Otolaryngologist and Radiologist.

The departmental academic and administrative offices are located on the 11th floor of the Medical Office Tower at EUHM. The address for the Department of Otolaryngology and the faculty is 550 Peachtree Street, NE, Atlanta, GA 30308. The phone # for appointments is 404-778-3381.

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Thank you,
Stephen Rashleigh, MD
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