

WINTER 2019



SCOPE

AMERICAN OSTEOPATHIC COLLEGES OF OPHTHALMOLOGY AND OTOLARYNGOLOGY- HEAD AND NECK SURGERY



The future of AOCOO-HNS

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Head and Neck Surgery Foundation
8201 Golf Course Rd NW Ste D#206
Albuquerque, NM 87120
855-262-6646 aocooHNS.org



2020 ACA New Resort Location: Mission Bay

We are so excited for our 104th Annual Clinical Assembly. The AOCOO-HNS staff have been working diligently to make this the best event yet. Due to unforeseen construction renovations on key amenities at the original venue, the 2020 ACA has been relocated to the amazing San Diego Mission Bay Resort (near Seaworld!). This venue will provide our attendees with an exceptional experience for our 2020 Annual Clinical Assembly.

The San Diego Mission Bay Resort offers a variety of amenities. With romantic palms and perfect sandy bayfronts, this bayside hotel retreat is complete with waterfront dining options, state-of-the-art event space, a spa/fitness center, and beautiful resort guest rooms for you to enjoy during your stay at ACA.

We hope to see you there!



SAN DIEGO
MISSION BAY
RESORT



2020 Annual Clinical Assembly
April 30th-May 2nd, San Diego, California

REGISTER TODAY: aocoohns.org

PRESIDENTIAL REPORT

Aging Patient Population The Medicare Highway

While enjoying a relaxing drive to Michigan for the weekend, I was listening to country music on my favorite radio station, and absorbing the beautiful colors of the fall foliage. Suddenly, my peaceful interlude was interrupted by another everlasting annoying commercial about Medicare targeting our aging patient population. The relaxation is quickly replaced with aggravation. Our aging patients' phones are constantly ringing, knowing they will always answer because they just can't ignore it. Infomercials filling the late and early hours on the television. My patients are confused. How often have you heard "but they told me"?

My office staff is having difficulty keeping up with the ever changing Medicare rules and regulations. Our elderly patients definitely do not understand them. PPO's and HMO's verses traditional or advantage plans: What does this mean? Remember the good old days when only traditional Medicare was available. It worked well and was easily understood. There was an annual deductible. Medicare covered 80% of fees and you required a secondary insurance to pick up the remaining 20%. Many secondary insurers included policies that picked up the annual deductible.

Our aging patients hear that their policy has no annual deductible and they don't remember anything else said about the policy. Just as a patient getting the diagnosis of cancer and discussing the treatment options with their physician, their mind shut off after the word "cancer" was said. All other conversation after that wasn't absorbed. There is no consistency within policies under the same company. Some HMO's require prior authorizations while others do not. Referrals are not the same as prior authorizations. My staff and I spend more time explaining insurance policies every day. The same dilemma occurs with physicians or surgical centers OUT of Network and IN their Network.

Companies change their employee plans without informing them that there are significant changes in their plans and providers. Patient volume is decreasing because they can't keep up with the constant changes. They want to avoid a shocking experience when receiving their billing informing that their insurance had denied the exam.

Patients have informed me that you were allowed to change back to traditional Medicare in the next open enrollment if you didn't like your advantage plan. Now I hear that once you make the switch to an Advantage plan, you've forfeited all rights to return to the traditional plan. Yikes! I am an advocate for educating my patients on health issues and this is becoming a recurring problem with many patients. It's time to have a face to face meeting with a representative from Medicare to better inform the physician and their staff to enable us to help our patients.

Hmmmm. Bet there is no boiling CPT for that.



**"Enjoy life with
its beautiful fall
colors."
-Dr. Davis**



Judy L. Davis, DO, FAOCO
AOCOO-HNS President

Leadership Development Program (LDP)

I am excited to announce to the membership of the AOCOO-HNS, the creation of a Leadership Development Program (LDP). The primary focus of this program will be to train future leaders of our colleges. The training may also be applicable outside of our organization. It can help participants to enhance their careers and enhance their work in other organizations in which they may serve. Participants will learn Robert's Rule of Order from Daniel Ivey-Soto, JD, a National Association of Parliamentarians certified professional parliamentarian. Additionally, participants will learn leadership skills from Robert Fritch, DO, who holds a master's degree in medical management. Finally, participants will learn how to read and understand financial statements from Mr. Bradley Morris a retired Chief Financial Officer.

The curriculum will also include the history of the AOCOO-HNS, helping to shape the Colleges mission, discussing the Colleges values, and helping to formulate the Colleges future. The participants will have the opportunity to dive deeply into the Colleges bylaws, board policies, annual reports, financials, educational programs, insurance coverage, and the strategic plan. The outcome will leave the participants prepared to become leaders within AOCOO-HNS.

**"This is an incredible opportunity"
-Ralph McClish, Executive Director**

Participation will be limited to three (3) members of the Colleges who will commit to 12 months of training beginning in May and must attend:

1. One (1) all expenses paid, one-and-a-half-day (1 ½ days), face to face live training.
2. Eleven (11) Webinars, one (1) per month.

Selected individuals will receive articles to read, and assignments to enrich their knowledge on how to be a leader in today's diversified environment. In the next few weeks the criteria for consideration will be posted on the aocooHNS.org website, followed by an email with a link to an electronic application.

If you are interested in participating in this Leadership Development Program, please fill-out the application. All applications will be reviewed, and the final candidates will be selected by the AOCOO-HNS Board of Governors. Please do not be discouraged if you are not selected for the first class. We plan on continuing this program each year. As we graduate more and more physician leaders from our program, we will create an LDP alumni group.

This is an incredible opportunity and should be seriously considered by all members, regardless of years of experience.



Ralph McClish
AOCOO-HNS, Executive Director

The Future of the AOCOO-HNS

The future of our college is a topic I think about often and have done so since the announcement of the Memorandum Of Understanding (MOU) which was prior to 2015. Once the task force of the AOA, AACOM and ACGME agreed to propose the single accreditation system for Graduate Medical Education I had my doubts that any of our programs would achieve accreditation from ACGME. All osteopathic residency programs had a time line of 5 years, from 4-2015 to 6-2020, to apply and hope to obtain the necessary accreditation.

As a result smaller colleges, such as the AOCOO-HNS, sustained a significant reduction in training programs. The AOCOO-HNS lost almost half of the otolaryngology residency programs and many ophthalmology programs as well. Currently for otolaryngology, 12 programs have achieved initial accreditation, with one program still trying for initial accreditation. Of the 12 programs that achieved ACGME accreditation one has received full accreditation which occurs after initial accreditation is achieved and a second site visit is performed, usually around 2 years later. This is the first year (2020) all initially accredited osteopathic programs are participating in the National Residency Match Program (NRMP) as there is no longer an osteopathic match. Additionally this opens up our programs to MD as well as DO student applicants. For those of you wondering, there are only 17 otolaryngology residency spots available from our 12 accreditation programs for our osteopathic students to apply to. There are fewer ophthalmology spots available. This realization of such a dramatic change in our ability to train future osteopathic otolaryngology and ophthalmology physicians has given me pause to consider the future of the AOCOO-HNS.

My perspective comes from being a program director and also being an AOCOO-HNS board member for many years. I feel the college has an excellent management team in place and the current and past board members are dedicated to seeing our college succeed for many years to come. I do have concerns about the significant reduction of the number of residents that will graduate each year in the future and wonder if the graduates of our programs will join and participate in our college. The purpose of the AOCOO-HNS is to oversee board certification, recertification and provide CME programs for our members.

As the ACGME transition progresses we will be providing fewer of these services. Once all of our residency programs are fully accredited and residents are participating for a full five years in an ACGME program, then they will be sitting for the allopathic board exam. We will still be able to provide recertification and CME to past members, but the challenge will be to find ways to keep new members engaged.

Going forward , if we can entice our residents to attend and participate in the Annual Clinical Assembly (ACA), they may be more likely to continue attending once they graduate. Graduating from an ACGME residency program may lead to more of our newer osteopathic otolaryngology and ophthalmology physicians attending the annual AAO-HNS and ophthalmology meetings. Our future depends on a successful ACA conference at an attractive location with a solid educational program. Our current college members do a great job of supporting the ACA and return year after year knowing the venue will be outstanding, the programs excellent, and to have the opportunity to meet up with past colleagues.



The Future of the AOCOO-HNS

To that end, I have asked several of my residents to give me their thoughts on the future of the AOCOO-HNS.

Jeff Singh, PGY5, feels the future of our college is important for osteopathic otolaryngologists “to meet and share their research and ideas and to help improve the way we all treat our patients. Additionally to help stimulate residents and medical students to pursue research ideas and have a platform to present their findings.”

Dan Hilton, PGY5, feels the future of our college may benefit from collaborative efforts with the AAO-HNS as many of our younger residents will be joining this academy. Additionally he sees our college assisting residents to attending meetings such as the ACA and help those residents interested in humanitarian trips.

Colin Bohr, PGY4, thinks the future of our college depends on the “value” its members gain from it. “From a resident standpoint, online resources such as lectures, learning programs, professional development resources and job search tools, would make the college more attractive to participate in.”

Eytan Keidar, PGY3, feels the future of our college is to provide an avenue for recertification for our members and CME opportunities. Although he is uncertain as to what the future may hold for all of us, he feels “the presence of the ACOO-HNS is reassuring and remains the backbone of osteopathic otolaryngology and ophthalmology physicians. Finally he does like the new logo of the AOCOO-HNS!

Colin Byrd, PGY3, also feels the future of our college is primarily for recertification of our members. He feels “the newer ENT residents from our programs will be more drawn to the AAO-HNS meetings.”

Ian Bowers, PGY2, thinks a big role our college can play in the future is to be a source of mentorship for osteopathic students interested in otolaryngology or ophthalmology residency programs. Additionally, he feels our college can provide a platform at the ACA for osteopathic residents to gain experience presenting research at a national meeting. Finally Dr Bowers feels our college is important because “it builds a community that is proud of our DO heritage”.

Chris Lenkeit, PGY1, who’s had little exposure to our college would like to see the future of our college “increase educational opportunities and networking opportunities through our conferences”.

Dan Lofgren, PGY1, sees the future of our college “providing mentorship for osteopathic residents for job opportunities and fellowships. As well as helping residents financially to be able to attend the ACA for networking and research presentation opportunities”.

Although most of our residents have little interaction with the AOCOO-HNS now that we are ACGME accredited, they all seem to value the existence of our osteopathic college and what it can offer them in the future. My hopes, through encouragement from our program directors and others, is that most if not all of our residents will become members of our college, participate in the ACA conference, and get involved. We need to explore and implement the ideas the residents mentioned in this article to keep our college relevant to all of our members now and in the future. Finally, we need to continue to provide osteopathic medical students an opportunity to train in our residency programs, and like many of us who came before, support the AOCOO-HNS.

“We need to continue to provide osteopathic medical students an opportunity to train in our residency programs, and like many of us who came before, support the AOCOO-HNS.”

-Dr. Shermetaro



Carl Shermetaro, DO
AOCOO-HNS President-Elect

The future of The AOCOO-HNS

The future of The AOCOO-HNS is an interesting topic to write about. There have been so many changes over the last few years that will impact our future, that it is truly hard to predict where we will be in 10 to 20 years. We know that with the advancement of the single accreditation system (ACGME) for residencies, both Ophthalmology and Otolaryngology will see a significant decrease in the total number of residencies. Going forward, both MD and DO candidates will now be competing for the same residency slots, where traditionally, they had been separated. Additionally, because the AOA and ACGME will be responsible for the certification, and accreditation, that will mean one less responsibility of the College. We also know that with the ever changing CME rules, it's hard to know how much Osteopathic non specialty or specialty CME will be required in the future. So ultimately, the only constant we can expect over the next 10 years is change. Having pointed all this out, I see the colleges continuing to have a strong impact on our lives and education. So, how can I be so optimistic in the face of all that is going on? There are plenty of reasons.

Due to outstanding leadership, both past and present, the Colleges are well positioned to thrive moving forward into the future. First, thanks to Dr. Dubin's amazing leadership, we have good resources to move forward. Second, during our brief time with 1500 management, we were able to upgrade our educational programs and gain the knowledge on how to continue to write needs assessments.

Thanks to Monstully, (our current management, Ralph and Mackenzie), not only have we been able to receive both MD and DO credits for our educational programs, but they are constantly coming up with new and exciting membership perks and opportunities. Our ACA meeting continues to evolve and be a fantastic event. Every time I have the opportunity to speak with some of the nationally and internationally known speakers who lecture for us, they always tell me what a great experience they had during our event, and with our group. I believe this is a huge strength for us, and is a way for the college to continue to stay healthy and important.



Moving forward, I think by expanding our attendance with some of our MD colleagues; as well as, MD and DO residents at the ACA, will ensure a healthy future for the college.

Furthermore, I believe going forward, we do need to have more interaction with our National counterparts, the American Academy of Ophthalmology and the American Academy of Otolaryngology. As part of that initiative, the past president of the American Academy of Otolaryngology will be our keynote speaker in California. In addition to this, I do think the AOCOO-HNS should try to have some presence at our academy meetings. This may be in the form of having a reception at the respective meetings for our members, residents both MD and DO's, and members of the various academy's leadership. I also think we should try to have members of the academies leadership come to the ACA annually, so they are familiar with our members, and we can meet them in a more personal setting. It is my opinion that this will make it easier to have MD's, and all residents feel included in our meetings.

Finally, I know there are challenges to our future, but I also think we are positioned to have a bright future. It will take some work, but we certainly have the leadership and capability to accomplish it.



Donald Morris, DO
AOCOO-HNS, Vice President





AMERICAN ACADEMY™ OF OPHTHALMOLOGY

Protecting Sight. Empowering Lives.

AAO Councilor, Donald Morris, DO, Recognized

AOCOO-HNS has a Representative in AAO Leadership Development Program XXII, AAO Councilor, Donald Morris, DO was recognized at AAO 2019 in San Francisco for his selection to the Academy's 22nd Leadership Development Program (LDP) class. Dr. Morris, nominated by AOCOO-HNS, joins 19 other ophthalmologists in the LDP XXII, class of 2020 chosen via a competitive selection process. In addition to US participants nominated by state, sub-specialty and specialized interest societies, the LDP XXII class also includes one international participant from Serbia who is representing the European Society of Ophthalmology. This incoming LDP class had an Orientation Session in San Francisco where they were introduced to their classmates, met Academy leaders, and heard project presentations from the graduating LDP XXI, class of 2019.

In January 2020, Dr. Morris will take part in a 2 ½ day interactive session in San Francisco where he will hear from AAO physician leadership, including 2020 Academy President Anne Coleman, MD, PhD, on a wide variety of leadership topics. During this session he will also visit the AAO headquarters and participate in skills training exercises. Next Dr. Morris will attend the Academy's Mid-Year Forum 2020 in April in Washington D.C. where he will have scheduled meetings on Capitol Hill with Senators, Representatives and healthcare staff to discuss issues important to the medical profession. During an advocacy session dedicated to LDP XXII participants, Dr. Morris will also hear from a member of the US Congress about building effective relationships with legislators and how best to advocate on behalf of patients. The final LDP session for the class of 2020 will take place in conjunction with AAO 2020 in Las Vegas.

Participants in AAO LDP XXII, Class of 2020

American Glaucoma Society
Pradeep Y. Ramulu, MD, PhD

American Osteopathic College of Ophthalmology and Otolaryngology- Head and Neck Surgery
Donald A. Morris, DO

American Society of Retina Specialists
Jessica D. Randolph, MD

American Society of Ophthalmic Plastic & Reconstructive Surgery
Edward J. Wladis, MD

Association of Veterans Affairs Ophthalmologists
Jennifer L. Lindsey, MD

California Academy of Eye Physicians and Surgeons
Roma P. Patel, MD, MBA

Eye Bank Association of America
Mark Greiner, MD

European Society of Ophthalmology
Jelena Potic, MD, PhD

Florida Society of Ophthalmology
Sarah Wellik, MD

Idaho Society of Ophthalmology
Nathan R. Welch, MD

Kentucky Academy of Eye Physicians and Surgeons
Jeremy D. Clark, MD

Louisiana Academy of Eye Physicians and Surgeons
Maria A. Reinoso, MD

Maine Society of Eye Physicians and Surgeons
Erin Lichtenstein, MD

Missouri Society of Eye Physicians and Surgeons
Steven R. Shields, MD

Montana Academy of Ophthalmology
Joseph P. Sheehan, MD

New York State Ophthalmological Society
Gennifer J. Greebel, MD

North American Neuro-Ophthalmology Society
John Jing-Wei Chen, MD

North Carolina Society of Eye Physicians and Surgeons
Jennifer F. Jordan, MD

Virginia Society of Eye Physicians and Surgeons
Kapil G. Kapoor, MD

Women in Ophthalmology
Lisa Nijm, MD, JD

The Official Logo Launch

During last year's Annual Clinical Assembly I brought an outsider's perspective, and a strong understanding of the process of branding, in addition to a keen eye for visual assets. As an artist, I tend to look at things a little deeper. Even though I was new to the American Osteopathic Colleges of Ophthalmology and Otolaryngology- Head and Neck Surgery (AOCOO-HNS), I observed a shift. Young leaders are rising and technology is changing medical education. A new generation of physicians are emerging with a fresh perspective and innovative ideas- improving the quality of training, education and patient care that will lead us into the future. AOCOO-HNS President Elect Dr. Carl Shermetaro spoke with me about changing the design of the colleges logo. I thought this would be a great opportunity to symbolize a new lens and positive movement towards the future of the AOCOO-HNS.



AOCOO-HNS
American Osteopathic Colleges of
Ophthalmology  Otolaryngology
Head and Neck Surgery



The Official Logo Launch

Why re-brand Change is important in organizations to allow members to benefit from the advances in technology, new opportunities, and bottom line it will add value to our organization. Re-branding can be a visual representation of our growth. Although we are a strong established brand in osteopathic medicine, a re-branding campaign seems necessary for an ever changing industry. What is the next step to creating our new brand identity?

As with all strategy, research and introspection are the most important steps. The colleges have over 24 years of branding, with different looks of the organization's logo along the way. Past logos have incorporated a skull or face. It was important to look at what we have used visually in the past and ask ourselves if it holds true to the osteopathic mission of AOC-OO-HNS. Our immediate past logo used text of our full organization's name placed in a circle around a face symbol.

**“The clean simplistic style marks a fresh, exciting phase in the life of the organization”
-Gerald Lovato**

The face icon has become the most memorable part of the logo, however the lengthy text was very hard to read. How can we change the text but not lose our audience?

Our goal is to strengthen the AOCOO-HNS's message and allow it to evolve. What is clear, is the American Osteopathic Colleges of Ophthalmology and Otolaryngology- Head and Neck Surgery IS a mouthful. My strategy was to simplify and harness the power and popularity of our brand, much like our partner the AOA. The American Osteopathic Association (AOA)'s simple logo is a great example of successfully using acronyms. We used interlocking O's to build off the past, and launch into our future. The original face icon from our last logo and the new icon sets to visually represent the connection between osteopathic medicine with ophthalmology, as well as osteopathic medicine with otolaryngology, and the connection between the two specialties. Emerald green was used to symbolize the balance and harmony among the two specialties. Crystal blue represents the charitable efforts in the service to others with healing grace and sensitivity, while upholding the dedication of the osteopathic principles of practice. Geometric sans-serif typeface: Avenir font, designed by legendary designer Arian Frutiger, has given us a clear easy-to-read title. All visual elements of our logo can stand alone or together in harmony as an icon for the AOCOO-HNS brand.

Brand awareness reminds our members we are here. The clean simplistic style marks a fresh, exciting phase in the life of the organization and paves the way with plans to continue the innovation in osteopathic medical training, education, and patient care.



Gerald Lovato
Monstully LLC., Creative Director

**MEDICAL SCHOOL
INSPIRATION**

**Think for yourself.
Trust your own intuition.
Another's mind isn't
walking your journey,
you are.**

The Future of Health Care Delivery

The delivery of health care in our communities is not meeting patient needs. It can take three months in my area to get a routine eye exam, six months to see a family physician, eight months to see a dermatologist and longer to see a rheumatologist. How can we distribute ourselves better and get our colleagues to offer the services that are most needed in our communities?

In our specialty fields of ophthalmology and otolaryngology we have multiple sub-specialties of glaucoma, cornea, LASIK, cataracts, retina, ocular motility, neuro-ophthalmology, otology, laryngology, rhinology, allergy, neuro-otology, cosmetics, and head and neck oncology. To best serve the majority of our patients, knowing the most about every sub-specialty will serve the greatest number of our patients, however fine tuning our surgical skills and knowledge base in specific sub-specialty areas, allows us to serve individual patients better and at higher competency levels.

In the future, to meet the needs of our patients and the collective health care delivery system, how can we bridge the gaps in routine care availability and sub-specialty availability, especially in our smaller cities and rural communities? Physician extenders will play a critical role, however they will not solve all of our problems with access and availability. Payment incentives, to physician and physician extenders, to practice in non-urban medical centers is still on the table and has been for twenty years, but it has not solved the health care access and distribution issues yet either.

Most of us would agree that "for profit" health care delivery systems should come to an end in the near future. Making money off healthy patients at the expense of socioeconomically and genetically disadvantaged patients is not acceptable. Pooling our insurance premiums was always intended to safeguard against unavoidable accidents, inheritable diseases, and chronic disease for the good of all patients not insurance or drug companies.

Most of us would agree that it is not acceptable for health insurance companies to spend less than half of their premiums on health care delivery. However, would we admit that it is also not acceptable for providers to limit or adjust the patients they see to strictly the profitable patients? How promptly do we instruct our schedulers to make an appointment for a pseudophakic patient with ocular allergies vs. a phakic patient having problems with glare at night or an appointment for a patient with a sinus headache vs. a patient wanting cosmetic rhinoplasty and a mid face lift?

We are all cognizant of the fact that a large cataract causing difficulty driving at night is probably more pressing of an issue than dry watery eyes but we are also cognizant that employee salaries, rent, and equipment contracts must be paid. Where is the balance? If I could see fifty patients a day and decrease the length of time to get an appointment, would I better provide care for my community? Would I still fill my surgical block time?

After reading the Cleveland Way by Toby Cosgrove, MD, I saw an example where the Cleveland Clinic, has approached this dilemma in a unique way. They have essentially mandated provider teamwork on behalf of their patients. Physicians have a yearly contract with benchmarks that must be met in order for the contract to be renewed. These benchmarks are aimed at patient centered health care. Cleveland Clinic physicians may have less autonomy, however they are part of a delivery system that assists the patient population for which hospitals, insurance companies and health care providers were intended to serve.

Medicine is and should continue to be a sacred profession. Medicine should not be a "for-profit" industry for anyone. No one should profit off the health care misfortunes of another. Physicians should be compensated for their unique knowledge and rewarded for their unique surgical skills that they have perfected over years of training and medical practice. Moreover in the future, we all must agree and adopt the philosophy promoted by Kaiser Permanente that as physicians we provide the right care for the right patient at the right time. Only a teamwork approach will allow us to create a health care delivery force that can get the job done at the end of the day.



Kristen E. Reidy, DO
AOCOO-HNS, Past President

Physician Health & Wellness



Find Your Why

One of the smallest words in the English language, yet one of the most impactful throughout our lives, is the word “Why.” According to Merriam-Webster, the word why is defined as “for what cause, meaning, or purpose.” It is the underlying function of everything around us, and helps us understand and make choices as human beings. As individuals, we focus on the why of everyday people, places, or things around us. It’s time to question our own why, our own cause, meaning, or purpose in order to lead a healthier fulfilling life. Understanding the process of finding your “why”, is the first step towards committing to a lifestyle change.

Does any of this sound familiar?

- I need to lose weight
- I don’t have the energy
- I don’t have the time
- I’ll start tomorrow

Now here is the same list asking why at the end of each thought:

- I need to lose weight

Why? Because I want to look better, and feel better about myself.

- I don’t have the energy

Why? Because I don’t get enough sleep at night

- I don’t have the time

Why? Because I am too busy with work, family, and everyday life.

- I’ll start tomorrow

Why? Because I can’t do it today

These are all very typical thoughts when it comes to exercise, nutrition, and overall wellness. But if you really take a close look at all of the above, you will find that these are nothing more than a series of excuses justifying current lifestyle habits. Taking steps towards a healthy lifestyle, and finding your why, must first begin with changing the current mindset.

Let’s start by changing the goals.

- I WILL lose weight
- I WILL have the energy
- I WILL create the time
- I WILL start tomorrow





Find Your Why

Next, let's change the "why". Why did I create these goals? The answer is simple. Because I want to be my best self. Being your best self means no regrets. It means accomplishing small goals in order to achieve the larger ones. It means setting reasonable expectations for yourself that keep you moving forward. Don't set yourself up to fail at the beginning. Why? Because you will fail.

Start with a plan.

I WILL lose weight

- 20-30 minutes exercise 3-4 times a week. (Pick something that is doable for you)
- Walking, running, gardening, playing with your kids, workout routine etc
- Make better food choices (this does not mean extreme dieting, or cutting out food)

I WILL have the energy

- Exercising and movement makes you physically tired, allowing you to sleep better
- Fuel your body with food that creates natural energy

I WILL create the time

- Commit to the same time everyday to create a routine
- Find group classes

I WILL start tomorrow

- Use an alarm
- Make a calendar appointment
- Just start. You cannot finish something you never start.

Finally, execute your plan. Do the exercise that works for you. Choose to skip the bowl of ice cream for dessert. Remember WHY you are doing this. To be your best self.



Having trouble getting started?

I have created a private Health and Wellness group that will offer tips on eating and exercise. This will be members only group that is designed to motivate and educate on all aspects of overall wellness. I encourage you to also share it with your patients that may be looking for some extra motivation. Let's do this together, and have fun!

If you have questions, or are interested in the group, you can email me at BeYourBestSelf4U@gmail.com. You can join the group directly by going to: <https://www.facebook.com/groups/1342355035924943/>

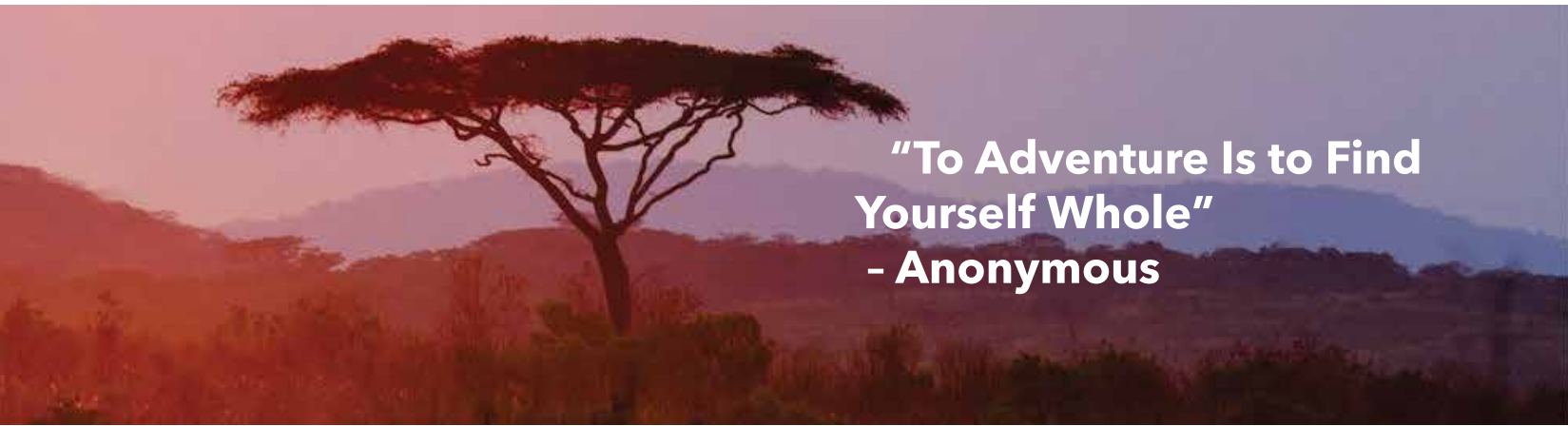


Jennifer McClish

*Information Privacy Manager
University of Utah Health*



**The Madgy Malawi
F o u n d a t i o n**



**"To Adventure Is to Find
Yourself Whole"
- Anonymous**



Scope | Page Fifteen



The Madgy Malawi Foundation: Global Health and Education

Malawi is one of the least-developed countries in Africa and ranked #6 as the poorest country in the world according to gross national income per capita in 2019. With an economy that depends primarily on agriculture, the majority of the people of Malawi live in rural areas with few resources and a very limited access to healthcare. Our team witnessed this first hand during our time in the country and we are very thankful for the opportunity to make a difference in the lives of these people.

On October 17th, three attending surgeons (Dr. Troy Creamean, Dr. Randy Zane and Dr. Kyle Robinette), as well as six otolaryngology residents (Jay Szekely, Jeffrey Singh, Luxman Srikantha, Bo Pang, Anya Costeloe and myself), along with an anesthesia team of CRNAs and RNs, arrived in Blantyre, Malawi. Our time was spent on the grounds of the Queen Elizabeth Central Hospital, which is the largest hospital in Malawi and the main teaching hospital for the University of Malawi College of Medicine. We operated at the Beit ENT clinic which consisted of two operating theaters and were able to perform approximately 34 operations, treating both adult and pediatric patients. The surgical cases consisted of laryngectomies, parotidectomies, thyroidectomies, neck dissections, pediatric nasal reconstruction, mastoidectomies and tympanoplasties. While we were there, we worked closely with Dr. Wakisa Mulwafu (the only otolaryngologist in Malawi) and his two residents. Our collaboration with one another strengthened a self-sustaining local otolaryngology service that the Malawi people will continue to benefit from even after we leave.

This year was the first trip representing The Madgy Malawi Foundation, which was founded on behalf of Dr. Madgy, who recently passed this year. Dr. Madgy first established a relationship with Dr. Wakisa Mulwafu about 10 years ago and now as a non-profit foundation, we hope to keep his legacy alive. Through donations, we have been able to provide new equipment in the operating theaters each year. In addition, as a participant on this trip, we each brought a large checked suitcase of donated medical and surgical supplies. We used these supplies while operating as well as donated the rest to the hospital to use until we return again next fall.

In Malawi, even with the disparities and challenges that these people face, they continue to fulfill their nickname, "The Warm Heart of Africa" with their welcoming and friendly spirit. Dr. Mulwafu provided all transportation while we were there and the hospital staff provided us lunch each day while we were at the hospital. I am so grateful to experience this hospitality and fortunate to be given the opportunity to be a part of an incredible team of physicians and nurses as we provided care to the people of Malawi. My adventure to Malawi allowed me to grow as a resident physician and deepen my commitment to my profession and the care I provide to all my future patients. This experience has also instilled a motivation to continue to working with global health and education that I will continue to pursue for years to come. Thank you.



"Through donations, we have been able to provide new equipment in the operating theaters each year."

-Dr. Larson



Aileen Larson, DO
AOCOO-HNS Resident

Malawi Medical Mission Trip 2019



Malawi Medical Mission Trip 2019

On October 17th, 2019, a group of attending physicians, residents, nurse anesthetists, and surgical nurses left the United States destined for Blantyre, Malawi. This was a partnership between the David Madgy Malawi Foundation (MMF) and the ENT clinic at the University of Malawi and Queen Elizabeth Hospital in Blantyre, Malawi. The goal was to bring ENT/Head and Neck surgical care to a population in need.

Malawi is one of the world's least developed countries marked by poverty, food insecurity, and a high prevalence of HIV/AIDS. Access to healthcare is extremely limited, especially among patients with ENT/Head and Neck pathology. Therefore, the goal of the MMF is not only to operate and provide surgical care to the people of Malawi, but also to help educate and teach surgical skills to the Malawian people in effort to develop sustained care.

For our trip, the goal was to perform somewhere between 30-40 cases, over a span of five days. After arriving into Malawi after a day of travel, the team settled into the hospital to prepare for the following days. With only two operating room theaters available, the team was able to perform over 30 cases.

The majority of cases were performed in effort to treat oncologic head and neck pathology, which included thyroid, parotid, oropharyngeal and laryngeal neoplasms. In addition, a number of otologic and pediatric otolaryngologic cases were performed as well.

After five continuous days of operating, the team completed a total of 32 cases. Simply put, people who would otherwise not have access to certain procedures, some life-saving, were able to get the care that they desperately needed. It was a joy and a blessing to be a part of such a mission. Lives were forever changed.

Although many cases were performed the week that we spent in Blantyre, there is much work that remains to be done. The grim reality is there are still so many people who desperately need access to healthcare and procedures that are not available to them. Because of this, it the ultimate goal of the MMF to build a long-lasting relationship with the University of Malawi and Queen Elizabeth Hospital to allow the opportunity to continuously return and continue this mission.

Traveling to Malawi and providing this type of care was truly an incredible experience, one that is hard to put into words. If interested in being part of this growing mission, please take the time to learn more about the Madgy Malawi Foundation. The foundation is always looking for people with a variety of gifts and skills to help provide education and surgical care to a people in need.



“If interested in being part of this growing mission, please take the time to learn more about the Madgy Malawi Foundation.”

-Dr. Singh



Jeffrey Singh, DO
AOCOO-HNS Resident



The Madgy Malawi
F o u n d a t i o n

**“This was one of the most
unique, rewarding and humbling
experiences of my life”
-Dr. Costeloe**



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The Madgy Malawi Foundation: Global Health and Education

Malawi is one of the world's least developed countries with a predominantly rural population economically dependent on agriculture. According to the World Health Organization (WHO), healthcare accessibility is sparse with one physician for every 20,000 individuals. Life expectancy is short, largely due to the morbidity and mortality surrounding infectious diseases, with the leading cause of death being HIV/AIDS. The populace is further limited by extreme poverty, a restricted infrastructure, and a scant supply of clean water and sanitation. These qualities demonstrate a need for sustained assistance in the growth and development for the country's future.

Dr. Madgy, a pediatric otolaryngologist out of Detroit, had led the Malawi otolaryngology medical mission for over ten years. The Madgy Malawi Foundation was founded this year on behalf of Dr. Madgy, who recently passed earlier in 2019. Dr. Wakisa Mulwafu, the only otolaryngologist in Malawi, with the support of donors and Dr. Madgy, developed an otolaryngology department and started a residency program at the Queen Elizabeth Central Hospital and the University of Malawi Medical College of Medicine. Using money from donations, each year new equipment has been acquired, allowing for the visiting surgeons to perform a wider variety of procedures. Michigan State University, a sponsor of this mission, has provided housing for the residents during the mission.

On October 17th, a team of ENT residents, CRNAs and nurses, led by Dr. Troy Creamean, head and neck surgeon. Dr. Randy Zane, neurotologist and Dr. Kyle Robinette, pediatric otolaryngologist, traveled from Detroit to Blantyre, Malawi; a journey that requires four flights and two days of travel. We spent each day operating at the Beit ENT clinic, a small ENT hospital on the campus of Queen Elizabeth Central Hospital. In the mornings, we would round on our post-op patients and see new patients that arrived. At the end of each day we would plan our surgeries for the next day. Between operating theaters one and two we completed a total of 34 cases. The surgeries we performed included laryngectomies, parotidectomies, thyroidectomies, neck dissections, pediatric nasal reconstruction, mastoidectomies and tympanoplasties. Most patients came from rural, under-served areas. Many of them have no access to transportation and walked, often along with their entire families, many miles from their villages to Blantyre. The families would set up camps on the hospital grounds and cook food over campfires to feed the patients.

Dr. Mulwafu made this trip possible by organizing and preparing the transportation, the hospital staff and the patients prior to our arrival. During our week in Malawi, we worked closely with him and his team of two residents. The Malawian residents scrubbed cases with us and we taught them various surgical techniques. We discussed each patient with them and the post-operative care they would require. This will provide continuity of care for the patients we operated on and allow for their postoperative needs to be met. We are staying in touch with Dr. Mulwafu throughout the year via email and he has been updating us on how the patients are doing.

It was an honor to be a part of the 2019 Madgy Malawi Foundation Medical Mission. This was one of the most unique, rewarding and humbling experiences of my life. I saw a significant growth in my surgical skills and patient care and was exposed to pathology we don't encounter in the United States. I am grateful to the AOCOO-HNS Foundation International GME grant for making this trip possible and I hope to return to Malawi next year.



Anya Costeloe, DO
AOCOO-HNS Resident

The Madgy Malawi Foundation: Global Health and Education

There is no one word that describes my experience in Malawi. The people, the country, the autonomy, the pathology, the staff, and my mentors and crew were beyond amazing. I grew as a person and as a surgeon so much, and this will go down as one of those moments in my life that changed everything.

Dr. Wakisa Malwafu is the only public ENT in a country of over 18.5 million people. The patients we operate on are selected by Dr. Malwafu and his staff and are told to come back during the week that we are present for their procedures. I have never seen a stronger and more resilient people. They walk in from all over the country side and stay at the hospital to get a procedure done. Their family members care for them pre and post operatively. Many patients don't speak English and we converse through interpreters, but their body language and facial expressions speak more than words. They are all so grateful for whatever we can do for them and would have likely gone without surgery if we did not arrive.

Throughout the week we performed 33 major procedures including, parotidectomies, tympano-mastoidectomies, thyroidectomies, rhinoplasty, submandibular gland excisions, laryngectomies, neck dissections, and ear canal repair. Drs. Troy Creamean, Kyle Robinette, and Randy Zane were our attending supervisors, and they were absolutely amazing. They allowed for our senior residents to proceed with complete autonomy. They were immediately available if we needed them, but they allowed us to struggle and learn through that struggle. They only scrubbed in to provide guidance or assistance if you were really in need of help. This pushed the residents to their limits. I myself learned that I am capable of nearly anything. It wasn't until this mission, that I truly felt ready to graduate from residency and practice on my own.



Scope | Page Twenty One

The staff in Malawi were hard working and we worked directly with them and the local residents to help provide them with experience. The residents were happy to scrub in with us and learn whatever we had to show and teach them. We discussed post operative care and were insured that our post operative patient would be well cared for when we left. Dr. Mulwafu took excellent care of us, coordinating dinners for us and all of our transportation. We always felt well cared for and secure. There was never a time we felt worried or that your security was compromised.

Malawi is the 6th poorest country in the world and this was evident everywhere we went. We were able to see some of the country and experience some of the culture of Malawi following the end of cases each day. Despite the economic struggles of the country the local people are kind and respectful. They have the utmost respect for visiting physicians, and we were often thanked by strangers for coming to their country to help.

I will never forget my time spent on this mission. It has lit a fire in me and I will be attempting to revisit Malawi as an attending physician and peruse future mission work. I will also continue working with Troy to continue the work they have started with the Madgy Malawi Foundation.



Jay Skelly, DO
AOCOO-HNS Resident

Surgical Medical Missions



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**The Madgy Malawi
F o u n d a t i o n**

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Haiku Poem by -Jordan Teitelbaum, DO



**Resident Burnout
you publish papers but you
don't really listen**

Future Directions: More Shared Knowledge in the Now

As a recent osteopathic otolaryngology residency graduate, I never had to worry much about 'the merger.' I knew I was Home Free. I knew I was proud to come out of the program. I knew that I dedicated time and effort to ACGME Site Visit paperwork to help a bit. I knew that change was somewhere (imperceptible?) on the horizon.

I definitely never knew what the actual 'deal' was. Perhaps as a trainee I was shrouded from key facts and updates, but I certainly did not know what to tell our auditioning medical students who asked me how our accreditation process was going. I enviously heard through the grapevine how some programs got fully credentialed. I mourned hearing about programs who ultimately had to bow out, including our beloved home ophthalmology program.

The real problem is: I still don't know. I had to Google "d.o. m.d. merger" today and found a wonderful article detailing the merger and what it means for DOs¹. I had to turn to Student Doctor Network, an opinion-based resource, to see how our accreditation processes were going². I have no idea how accurate these blogs are, and I wish I could get my information righteously.

One issue is the lack of transparency I feel from our academy. More precise updates and announcements would be helpful to those applying. It also creates accountability and keeps everyone involved - all of us - in the loop. Perhaps this would even foster an atmosphere of collaboration: What did you do to get in? Why was your paperwork deemed deficient? How did the site visit go?

The other real issue is our lack of technological updates. This is most true on our academy website. The list of actual residency programs, current residents, and program directors was last updated in February 2016³. How are candidates supposed to know who is open, who is new, who is running the show? This website could - and should - be the main go-to resource with everything a current member or prospective member would need to know. Dedicated efforts or mandates for each program to help keep information current would be paramount.

At my first Annual Meeting in Orlando, I felt at home. I know that our feeling of camaraderie will continue as we merge. When I attend larger AAO/HNSF or sub-specialty meetings, I'm always on the lookout for "D.O." on someone's badge so we can chat or catch up. I feel both perseverant and special to 'swim in the big MD ENT pond' yet to have my own secret community with bonds formed that only we would understand.

Thus, we should urge ourselves to keep up with the times, and beseech our physician leadership to keep information resourceful and contemporary. I hope we can push towards a centralized source for all those involved to glean updates and provide opportunities for those to network and advance their careers. I know that whatever does happen in the next several years of the AOCOO-HNS as these overwhelming and overarching yet unclear and unproven changes occur, we will have a bright near future just like our booming present.

Figure 1²:

Ophthalmology

- 8 programs applied
- 4 initial/continued accred (2 DO PD's)**
- 4 pre accred

Otolaryngology

- 15 programs applied
- 10 initial/continued accred (9 DO PD's)**
- 4 pre accred
- 1 withdrawal

References:

1. <https://blog.matcharesident.com/5-ws-of-the-acgme-merger-mddo-merger/>
2. <https://forums.studentdoctor.net/threads/heres-the-current-status-of-aoa-programs-that-have-applied-for-acgme-accreditation-by-specialty.1359645/>
3. <https://www.aocooohns.org/storage/app/media/documents/042136db81bd49c1eb1b73b425af1bba1.pdf>



Jordan Teitelbaum, DO
AOCOO-HNS Otolaryngologist/ENT

FYI Corner:

Osteopathic Continuing Certification: Modernizing Cognitive Assessment

For those of us with time dated ophthalmology or otolaryngology specialty certificates we are required to take a written exam every ten years. This is Component 3: Cognitive Assessment of the Osteopathic Continuous Certification (OCC). This exam may be taken three years prior to the expiration date of our board certification and costs approximately \$2,000. This exam has historically been more clinically oriented as compared to our initial written and oral board examinations. Ophthalmologists and Otolaryngologists with non-time-dated or non-expiring board certification are not required to participate in OCC however they may elect to participate voluntarily if they choose.

The Task Force on Osteopathic Specialty Colleges, of which Kristin Reidy DO is a member, is working with the AOA to make continuing certification more relevant and user friendly to AOCOO-HNS members. A written exam administered every ten years to a group of physicians admittedly has its pitfalls. To address this there is a national push to provide physicians with monthly Cognitive Assessment articles with follow up questions in areas that might be more directly applicable to a doctor's individual practice focus.

One by one, specialty boards like ours will likely launch such modernized Cognitive Assessments. The American Osteopathic Board of Obstetricians and Gynecologists (AOBOG) recently launched their "Advanced Real-time Certification" (ARC), an online longitudinal assessment program that allows its physicians to fulfill their OCC Cognitive Assessment Component 3 requirements more conveniently over time, rather than through an in-person recertification exam.

The OBGYN ARC participants complete 24 online assessment items annually (8 per quarter for the first three quarters of each year). During the fourth quarter, they have the opportunity to revisit any items answered incorrectly during previous quarters. Items answered correctly during this second-chance round will cancel out the previous responses and count toward your overall score.

To maintain their OCC Cognitive Assessment requirements for their sub-specialty, OBGYN physicians need to complete 10 assessment items annually. During the fourth quarter, they have the opportunity to revisit any items answered incorrectly during previous quarters.



AOBOO-HNS Announcement

To All Eligible AOBOO-HNS Written Qualifying Examination Candidates:

Registration is now open for the upcoming AOBOO-HNS Written Qualifying Examination that is scheduled from May 1-14, 2020 at Pearson Vue testing centers. The application deadline is Thursday, April 16, 2020.

If you would like to register for the Written Qualifying exam, please visit www.aoboo.org and click "APPLY". You will be able to register using the application on the AOBOO website and upload your documentation once you login to the site using your AOA login information.

Registration FINAL deadline for this examination is Thursday, April 16, 2020. The exam will be available at Pearson Vue locations from May 1, 2020-May 14, 2020. The examination fee is \$1500 on the AOBOO-HNS website.

The 1st registration deadline will be Tuesday, March 17, 2020. Registrations received after the FIRST deadline will be subjected to an additional \$250 late registration penalty.

If you plan to register for this exam, please do so as soon as possible in order to ensure availability at your local testing center.

Please note you can not register at Pearson Vue until your application and documents have been approved by the AOBOO. The turnaround time for approval will be three weeks from when we received the AOBOO Written Qualifying application and documents. We encourage you to apply as soon as possible so you can reserve a date and seat at a testing location near you.

The AOBOO-HNS is hosting the AOBOO-HNS Oral Exams on April 28, 2020 at San Diego Mission Bay Resort, 1775 East Mission Bay Drive San Diego, CA 92108.

Do not hesitate to contact AOBOO-HNS office for additional information or assistance. The AOBOO-HNS phone number is 312-202-8154 and the email is aoboo@osteopathic.org.

CMV and Hearing Loss in Infants

Human cytomegalovirus is known to be a significant cause of hearing loss in infants. Human CMV belongs to the family of Herpes viruses. The incidence of CMV in the general population of the United States increases with age leveling off at 80-90% by eighty years of age.

CMV affects between 20-40,000 infants per year and is the most commonly transmitted virus to a fetus. In developed countries, 50% of women of childbearing age have evidence of CMV infection (i.e., CMV seropositive). It is the most common congenital infection in newborns. Intrauterine infection can occur during any trimester of pregnancy. Transmission to a fetus during the first trimester, however, is associated with the greatest risk of severe fetal infection and subsequent developmental sequelae. These sequelae can include mental retardation, neurological defects, cerebral palsy, seizures, developmental delays and loss of vision. Over one-half of symptomatic infants will have long-term sequelae. Infection is most often asymptomatic in 85-90% of the time and is symptomatic in the other 10-15% of infants. Lower rates of neurodevelopmental sequelae are reported in asymptomatic infants, with sensorineural hearing loss being the most common manifestation.

About 12% of CMV infected infants will experience some degree of hearing loss; 30% of these infants will have other symptoms and 10% will have no other symptoms. Among the symptomatic infants, most will have a bilateral loss and asymptomatic infants will have a unilateral loss. In both groups, the hearing loss is usually severe to profound. The hearing loss may be delayed for 6-7 years and can be unstable, fluctuating or progressive.

Hearing loss due to CMV does not have a pathognomonic audiometric configuration and varies in the severity of the loss. Complicating estimation of its incidence is the fact that less than half of the affected children are born with the loss and the other half do not develop it until the early elementary school years.

Since CMV is becoming increasingly recognized as a causal factor in a variety of newborn symptoms, especially SNHL, there has been increasing interest in the screening for CMV in newborns who have failed their newborn hearing screens. Congenital CMV infection can only be confirmed if the newborn is tested in the first 3 weeks of life. Recent trials have found that CMV PCR performed on salivary samples are both sensitive and specific and might be considered as the investigation of choice for diagnosing congenital CMV infection in newborns.

There are been some studies that have shown that early identification and treatment with antivirals may help stabilize hearing loss in infants with CMV related SNHL. While there is no consensus on anti-viral therapy in these infants yet, it is important to note that early identification and early intervention with audiology and speech can have a profound effect on these children as compared to identification at an older age.



Ankur Patel, DO
AOCOO-HNS, Secretary/Treasurer

Education Committee Update

Lyndsay Madden, DO

AOCCO-HNS Education Committee, Chairman

There is a great deal of energy and excitement brewing among members of the AOCCO-HNS Education Committee surrounding the planning of the 2020 Annual Clinical Assembly to be held in San Diego, CA. Both the ophthalmology and otolaryngology sections are planning lectures, panels, and workshops to engage membership on many levels. The 2020 program chairs, Dr. Namrata Varma (otolaryngology) and Dr. Tim Winter (ophthalmology), have both been doing an excellent job leading the education committee members in planning what I know will be an excellent, educational, and clinically relevant meeting. With the leadership of the program chairs, committee members are working diligently planning lectures to be given by international experts across the many sub-specialties of both ophthalmology and otolaryngology.

I am also pleased to announce that this year's keynote lecturer will be Dr. Albert Merati. Dr. Merati is an otolaryngologist who serves as chief of laryngology at the University of Washington. Dr. Merati is the immediate past president of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) where he served a one-year term to nearly 12,000 members. Following medical school at UW, he completed his otolaryngology training at the University of California, San Diego, including one year of National Institute of Health research training. Dr. Merati then went to Vanderbilt University to study with Dr. Robert H. Ossoff and Dr. James L. Netterville. Dr. Merati has over 110 peer reviewed publications and is the lead editor for the Textbook of Laryngology. In addition to holding a number of leadership positions within the AAO-HNS and on the Councils of the Triological Society he is also the current president of the American Broncho-Esophagological Association. Dr. Merati plans on speaking to our membership on "Leadership: is it about you or is it about me?" where he will touch on selfishness/selflessness, career goals, politics, tough decisions and the reckoning we must face for our own professional decisions in our personal lives. A topic that will certainly be pertinent to each of us. You will also be able to catch Dr. Merati speak during the laryngology section of the main program. Stay tuned for more exciting updates and I look forward to seeing each you in 2020!



Meet the AOCOO-HNS Board of Governors Nominees

I was born and raised in southeast Michigan in a small town on lake Erie. I received my B.A. in Health Administration from the University of Michigan in 1986. I graduated from Michigan State College of Osteopathic Medicine in 1990. I completed my ophthalmology residency at Grandview Hospital in Dayton Ohio in 1995, where I have been in practice ever since (25 years).

I became the residency director for ophthalmology at Grandview Hospital in 1997, and continued in this role for 17 years, before stepping down in 2014. I have been a member of the Council of Osteopathic Medical Education (COME) from 1998-2015. I have served as the co chair for the awards committee since 2008. I became a member at large for the Board of Governors in 2016.

I have always believed it is important to be an active part in our college. I am now happy to offer my service as the Secretary/Treasurer for the Board of Governors and would appreciate your support.



Robert L. Peets, DO
AOCOO-HNS Secretary/Treasurer Nominee



Lyndsay Madden, DO
AOCOO-HNS Member-at-Large Nominee

Since 2015 I have been working as an Assistant Professor of Otolaryngology at Wake Forest School of Medicine. I completed my residency in Otolaryngology at Grandview Medical Center in 2014 and subsequently completed a fellowship in Laryngology at the University of Pittsburgh in 2015.

It has been a true honor to serve on the Board of Governors as a Member-at-Large for our College for the past term and I am excited to run for a second term to continue my service to this organization.

Since 2013, I have been closely involved with the College on many levels. I have been a lecturer, panelist, and moderator at many of our meetings, served as the educational program chair of both the Mid-Year Seminar in 2016 and the Annual Clinical Assembly in 2018, and participated as the laryngology representative on the Education Committee where I now serve as the Chairperson.

Each of these opportunities to serve our membership has engendered an even deeper desire to continue as part of the College's BOG, especially with our rapidly morphing healthcare landscape. These uncertain times call for forwarding-thinking leaders who anticipate change and adapt. It is my sincere wish to continue to serve as such a leader in the AOCOO-HNS and provide the membership with the necessary support to grow as a sub-specialty, and it would be a distinct privilege to continue to do so in the capacity of Member-at-Large.

Dr. Julia Agapov is a board-certified ophthalmologist with sub-specialty training in glaucoma in Madison, Wisconsin. She is affiliated with SSM Health St. Mary's and St. Clare Hospitals, and an Assistant Professor at the department of Ophthalmology and Visual Science at UW Madison School of Medicine.

Dr. Agapov received her Doctor of Medicine degree from Russian State Medical University in Moscow and Doctor of Osteopathic Medicine from New York College of Osteopathic Medicine. She completed her Ophthalmology residency at Metropolitan Hospital in Grand Rapids Michigan and fellowship in Glaucoma at Indiana University School of Medicine. Her clinical interests include medical and surgical management of glaucoma and cataract surgeries.



Julia Agapov, DO
AOCOO-HNS Member-at-Large Nominee

CASE REPORT

Spontaneous fracture of both Polyimide haptics 14 years post-operatively

A 60-year-old female presented to our office in October 2016 with a sudden marked decrease in vision in her left eye for 6 days. She denied any history of trauma.

Uneventful phacoemulsification with in-the-bag insertion of a Staar AQ2010V 3-piece IOL OU were performed by myself one week apart in October 2002. Routine Yag capsulotomies were later performed in 2004 OD and 2006 OS.

Examination of the left eye revealed vitreous prolapse into the anterior chamber with fractured polyimide haptics, both distal ends fibrosed into the capsular bag. The optic was resting on the retina.

Since the patient was symptomatic from the optic floating in the vitreous, our vitreo-retinal surgeon performed a pars plana vitrectomy, and the optic was explanted through a limbal incision and exchanged for sulcus-fixated IOL.

Two other cases have been reported with a late fracture of one polyimide haptic. [1,2] This is the only reported case of a simultaneous fracture of both polyamide haptics.

References

1. Stallings, S., Werner, L., Chayet, A., Masket, S., Camacho, F., Cutler Peck, C., Mamalis, N. Intraocular polyimide intraocular lens haptic breakage long-term postoperatively. J Cataract Refract Surg. 2014;40:323-326.
2. Kang H, Han KE, Kim TI, Kim EK. Spontaneous fracture of an implanted posterior chamber polyimide intraocular lens haptic: a case report. Indian J Ophthalmol. 2014 Mar;62(3):348-50. doi: 10.4103/0301-4738.111195.



Staar Optic Explanted from Left Eye



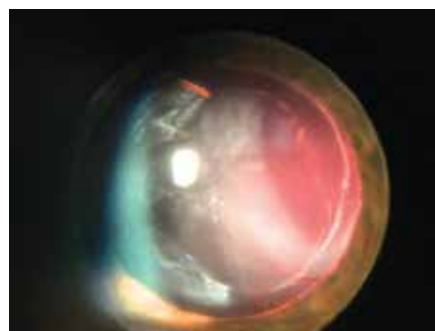
Left Eye Post-operatively with Sulcus-fixated IOL

Dr. Phillips is a board-certified Ophthalmologist specializing in Cataract Surgery at:

Phillips Eye Center,
619 River Drive,
Elmwood Park, NJ 07407
Email: hhp2020@aol.com



Right Eye - Pseudophakic with 3-piece Staar IOL



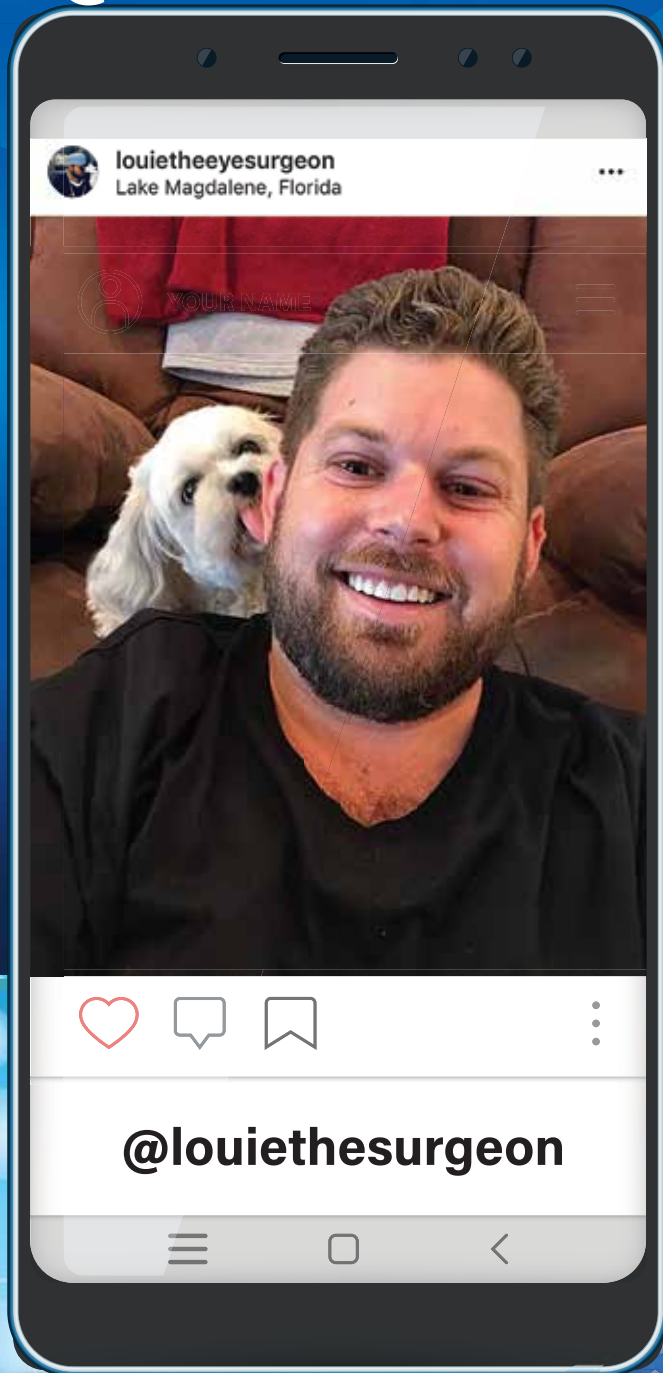
Left Eye - Aphakic with 2 Fractured Polyimide Haptics



Hadley Phillips, DO
AOCOO-HNS Member

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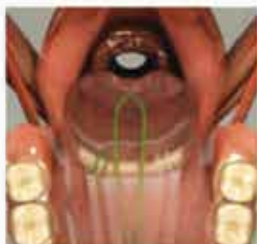
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Six reasons why ProMed is the right choice to maximize the value of your practice and help you find the right partner.

- #1.** Rudy Manthei, D.O. developed a solo practice into a 14 physician group with 9 clinic locations, an ASC with three ORs, and a yearly revenue of over \$14,000,000.
- #2.** Rudy Manthei, D.O. networked an Ophthalmology/ Optometry IPA/MSO consisting of four practices, with a net revenue of over \$70,000,000 that managed over 80,000 Medicare Advantaged lives in a risk-based contract ultimately with physician payment over 100% of Medicare.
- #3.** ProMed knows the steps required to maximize EBITDA and manage the process.
- #4.** Rudy Manthei, D.O. has personally experienced the entire PE process, ultimately obtaining a double digit multiple on a \$70,000,000 practice platform, uniquely positioning ProMed to specialize in the representation of small to medium practices.
- #5.** We have the experience and connectivity to know who the right PE partners are to drive growth, improve patient and employee satisfaction, and reduce stress for providers and staff while maintaining clear clinical separation.
- #6.** ProMed will drive the process and assist with all aspects of negotiation.

As a physician, Rudy Manthei, D.O. has a fundamental understanding of the challenges and pitfalls that you will face, and most importantly he will match you and your practice with the appropriate Private Equity Partner to achieve your goals. ProMed will deliver the best deal with the highest likelihood of long-term success.



HAPPY NEW YEAR

2020

JOY • PEACE • LOVE

Dear Members,

As a New Year is approaching, the AOCOO-HNS staff would like to take this opportunity to thank all of you for the great contributions made this year. It is truly an honor to work with so many wonderful innovative osteopathic professionals. All of you are what make AOCOO-HNS what it is. Thank you for allowing us to be on this journey with you. We are excited for another amazing year ahead.

Wishing you the very best before this old year is through. And may all of your dreams and aspirations come true. Happy New Year.

Sincerely,



AOCOO-HNS Staff



AOCOO-HNS

American Osteopathic Colleges of
Ophthalmology  Otolaryngology
Head and Neck Surgery

8201 Golf Course Rd NW Ste D#206
Albuquerque, NM 87120

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