Baylor College of Medicine

BOBBY R. ALFORD DEPARTMENT OF OTOLARYNGOLOGY HEAD AND NECK SURGERY

SUMMER 2017 • VOL 6

BCM CURRENTS

ADDRESSING THE ELUSIVE NASAL VALVE

KRISTA L. OLSON, MD, FACS
Associate Professor
Director, Baylor Facial Plastic and Reconstructive Surgery Center

Nasal obstruction affects a significant percentage of our population and can be attributed to a variety of fixed structural conditions including nasal septal deviation, turbinate hypertrophy, nasal polyposis among other conditions. What is less well understood is the role of dynamic nasal valve insufficiency in the spectrum of nasal obstruction. Studies estimate that approximately 13% of the general population suffers from nasal valve collapse resulting in nasal obstruction. [1] This dynamic collapse may be due to inherent lack of nasal sidewall support that often worsens with age, previous nasal surgery, trauma with separation of the upper lateral cartilage from the nasal bones among others. Nasal valve collapse has been the subject of recent investigation as patients who have undergone surgical intervention to assist with fixed obstructive issues not infrequently present with postoperative obstruction secondary to unaddressed nasal valve incompetence.

Assessment of nasal valve insufficiency is sometimes difficult in the setting of other obstructive phenomenon. When examining a patient with a severe septal deviation, for example, it is often challenging to appreciate the extent of the valve collapse because the limited airflow through the restricted nostril may not be sufficient to trigger the extent of the nasal valve collapse that would be seen if there were greater airflow. Also, it is sometimes difficult to perform a modified Cottle maneuver in these patients because simply inserting

CONTINUED ON PAGE 3

MESSAGE FROM THE CHAIR

DONALD T. DONOVAN, MD, FACS
Olga Keith Wiess Professor & Chair

Dear Friends,

The end of the academic year brings the graduation of our departing chief residents and the arrival of five medical school graduates who have been chosen to join our training program.

The past academic year has seen changes, milestone accomplishments and continued evolution and positive growth of the department. Here are just a few of the highlights.

Dr. Bobby R. Alford became Distinguished Professor Emeritus and he and Mrs. Alford split their time between their home in Houston and their house on Galveston Bay.

In early March we welcomed Dr. David Haynes as a Visiting Professor. Currently Vice Chair, Department of Otolaryngology at Vanderbilt University and Director of the Otology and Neurotology division,

CONTINUED ON PAGE 2

MESSAGE FROM CHAIR
CONTINUED FROM PAGE 1

Dr. Haynes presented "Contemporary Management of Sensorineural Hearing Loss" at Grand Rounds. He then graciously joined Dr. Alex D. Sweeney to teach a temporal bone dissection course for our PGY3 and PGY4 residents.

In late March, Dr. Bert W. O'Malley, Jr. delivered the 3rd Annual Bobby R. Alford Grand Rounds Distinguished Lecture. This lecture was established with a generous donation to Baylor College of Medicine from The Helis Medical Research Foundations to recognize and honor Dr. Alford in perpetuity for his years of dedicated service to the College.

Dr. Kenneth W. Altman completed his tenure as President of the American Laryngological Association. He delivered a thought provoking Presidential address at COSM in April 2017.

Dr. Deepak Mehta served as Program Chairman for the American Society of Pediatric Otolaryngology annual meeting in Austin, Texas, where the department was extremely well represented on the podium presentations, poster entries and panel discussions.

Dr. Danny Chelius completed his year as President of the Houston Society of Otolaryngology-HNS and Dr. Alex D. Sweeney was elected Secretary-Treasurer for the incoming academic year. Baylor College of Medicine Residents, Dr. Daniel Fox and Dr. Omar Ahmed earned 1st and 3rd place ribbons respectively in the annual Resident Research Competition sponsored by the HSO at their May meeting.

This issue of the newsletter highlights some of the people who are contributing to patient care, education and innovation in the areas of Facial Plastics and Reconstructive Surgery.

DONALD T. DONOVAN, MD, FACS

SKIN CANCER MOHS RECONSTRUCTION

K. KELLY GALLAGHER, MD
Assistant Professor

The incidence of both melanoma and non-melanoma skin cancers (basal cell carcinoma and squamous cell carcinomas) has been increasing over the last several decades. A recent analysis of Medicare Claims data showed that procedures performed for non-melanoma skin cancers (NMSC) nearly doubled from 1994 to 2006[1]. The number of procedures continued to increase by 13% from 2006 to 2012. The total number of people estimated to be treated for NMSC in the United States in 2012 was more than 3.3 million[2]. The primary goal in treating skin cancers is preventing recurrence via surgical excision with clear margins. Surgical treatment of these skin cancers involves either wide local excision or MOHS resection.

Closure of MOHS defects or larger skin resection defects involves several reconstructive options. Very small defects, particularly on concave surfaces, may be allowed to granulate in by secondary intention. Defects larger than 5mm are usually closed either with primary closure, skin grafts, or local flap reconstruction. As long as the defect area can be closed without adversely affecting or distorting surrounding structures, primary closure via adjacent tissue undermining is a suitable option.

For larger defects involving the face, or with complex locations such as the nose and lips, local flaps or skin grafts are necessary for reconstruction. Local flap reconstruction involves rotating or advancing tissue surrounding the defect to close the wound. Commonly utilized single stage flaps include the bilobe flap, V-Y flap, rhomboid flap or cervicofacial advancement flap. For nasal defects, two stage flaps, such as the melolabial flap or paramedian forehead flap are often performed to allow for a better thickness and subunit match. These flaps are based off of a pedicle and require delayed division after neovascularization from the recipient bed has taken place. Auricular cartilage is also often utilized in nasal reconstruction to maintain optimal nasal function and appearance.

Skin graft reconstruction can be a good option in patients that have shallow defects, thin skin at the defect site, or want to avoid two-staged surgery. Skin grafts involve harvesting tissue from a regional or distant site with primary closure of the donor site.

Regardless of which technique is employed for reconstruction of defects after skin cancer resection, the goals are consistent – 1) to obtain an optimal functional and aesthetic outcome and 2) to promote adequate and timely healing in cases where adjuvant postoperative treatment, such as radiation, is necessary.

1. Donaldson MR, Coldiron BM. No end in sight: the skin cancer epidemic continues. *Semin Cutan Med Surg.* 2011 March; 30(1)3-5.
2. Rogers HW, Weinstock MA, Feldman SR, Coldiron BM. Incidence Estimate of Nonmelanoma Skin Cancer (Keratinocyte Carcinomas) in the U.S. Population, 2012. *JAMA Dermatol* 2015 Oct; 151(10): 1081-86.

SUNSCREEN – THE TRUTH BEHIND THE SPF NUMBER

KIM CHANG
Aesthetician

According to the Centers for Disease Control and Prevention several risk factors play a role for different types of skin cancer. Some risk factors include: lighter skin color, family history of skin cancer, and exposure to the sun through work and play.

There are two types of sun ultraviolet (UV) radiation, UVA and UVB. UVB is what causes burning, and UVA is more associated with aging – wrinkles, leathering, and sagging. All of which can exacerbate cancer risk. Broad spectrum sunscreen helps prevent both UVA and UVB radiation from reaching the skin.

Other than choosing a broad spectrum sunscreen, it is important to understand Sun Protection Factor (SPF). SPF is not the strength as many may believe, but helps determine the length of time of how long the skin is protected from radiation. The SPF number lets you know how much longer your skin will be protected. Say it takes 20 minutes for your skin to turn red in the sun, an SPF 15 prevents reddening 15 times longer, which is about 5 hours. In terms of percentage filter, an SPF 15 filters out about 93% of all incoming UVB rays, while an SPF 30 filters out 97%. Regardless of number, sunscreens do not block all UV rays completely.

Although it's great to understand the SPF value, regardless of how high the number is, no sunscreen is expected to stay active for longer than 2 hours without reapplying. A great rule of thumb while out on the beach or swimming is about every hour, and during work or leisurely play – every 2 hours.

Other preventative measures to take throughout the year is to remember to seek shade between 10AM-4PM where UV radiation is strongest. Checking the UV index in your area is also helpful. The index scale indicates at what hour the UV rays are strongest within the day. Wear big brimmed hats during peak hours and examine your skin every month. Look for any suspicious spots that may have grown and use the ABCDE rule: Asymmetry, uneven Borders, changes in Color, larger Diameter than a pencil eraser, and moles that are evolving. Also, schedule to see a Baylor dermatologist every year for a thorough head-to-toe skin exam.

ADDRESSING THE ELUSIVE NASAL VALVE
CONTINUED FROM PAGE 1

Method of correcting internal nasal valve collapse using bilateral spreader grafts

an instrument like an ear curette or a cotton-tip applicator can be challenging depending on the extent and location of the septal deviation. If the nasal valve is not addressed, however, the effects of increased airflow that are seen after surgical intervention including septoplasty and turbinate reduction will trigger noticeable valve and nasal sidewall collapse. This is in contrast to the patient with dynamic nasal sidewall collapse without a prominent septal deviation. In these patients, the collapse is often a result of the vacuum effect created when air flows through a narrow tunnel (Bernoulli effect).[2]

Example of alar batten graft placement to correct lateral nasal wall insufficiency as well as nasal valve collapse

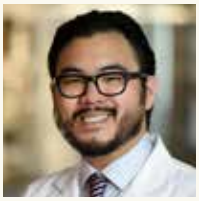
There a variety of methods described for surgical correction of nasal valve collapse including grafting techniques (alar batten grafts, crural strut grafts, spreader grafts) as well as suture techniques (flaring, suspension to inferior orbital rim). Recently, an FDA approved absorbable polymer device (Latera®) has been shown to improve nasal breathing in patients with nasal valve insufficiency. The surgical plan should consider the individual patient's areas of obstruction as well as factors such as skin thickness, availability of grafting material and need for concomitant sino-nasal procedures.

The Baylor Facial Plastic and Reconstructive Surgery Center is currently investigating the role of different types of grafts used for nasal valve reconstruction in obstructive sleep apnea (OSA) patients to determine if we can improve their symptoms and apnea-hypopnea indices on polysomnography. We already know the important role nasal surgery has for these patient in terms of improving CPAP compliance, but what remains to be understood is the role correction of nasal valve collapse has in OSA as an isolated procedure.

REFERENCES:

1. Aksoy F, Veyseller B, Yildirim YS, et al. Role of nasal muscles in nasal valve collapse. Otolaryngol Head Neck Surg 2010; 142:365-369.
2. Chan D, Shipchandler TZ. Update on the evidence for functional rhinoplasty techniques. Curr Opin Otolaryngol Head Neck Surg 2015; 23:265-271.

MICROVASCULAR (FREE FLAP) RECONSTRUCTION OF LARGE HEAD AND NECK SKIN DEFECTS



ANDREW T. HUANG, MD
Assistant Professor

Reconstruction of the face, head, or neck after removal of skin cancer or traumatic injuries requires surgeons that have expertise in all rungs of the "reconstructive ladder" in order to provide the best possible outcome (Figure 1). The ideal reconstruction of skin defects, especially those in cosmetically important areas like the face, head, and neck, means minimizing or hiding scars while also providing new skin of similar color, thickness, and texture. For this reason, primary closure or local flap repair are often the most cosmetically appealing techniques as they involve borrowing neighboring skin of similar quality to replenish what was lost[1]. Although secondary intention healing and the use of skin or biologic grafts can be excellent methods in specific cases, these can often lead to prolonged wound healing times and widened or distorted scars. In some cases, skin defects are too large or complex for any of these repair techniques. If indicated, these wounds may be amenable to microvascular free tissue transfer reconstruction. In microvascular free tissue transfer reconstruction, tissues (for example bone, muscle, nerve, skin) removed in cancer surgery are systematically reconstructed and replaced by similar tissues taken from a distant site of the body by means of transplantation. These composite tissue transplantations require harvesting of the reconstructive tissues with their associated blood supply. The blood vessels, on average only one to three millimeters in diameter, are then sutured with the aid of a microscope to an artery and vein near the defect so that the transplanted tissue can survive in its new environment (Figure 2). Similarly, nerves can also be reconstructed with these microsurgical techniques providing means for patients to regain either sensory or motor function lost in their cancer removal surgery. Donor

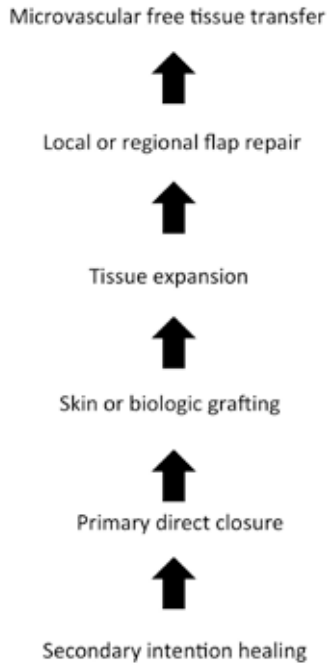


Figure 1. The "Reconstructive Ladder".

Figure 2. Microvascular surgery. A. Size of microvascular suture needle compared to a penny. B. Microvascular surgical connections (anastomosis) between arteries (arrow) and veins (asterisk).

tissues for these types of defects are most commonly retrieved from the thigh, forearm, lower abdomen, or back. While this procedure is an extensive surgery, in select cases it may provide the best option in providing full thickness skin and soft tissue to optimize the cosmetic result, while also minimizing wound healing time and preventing delay in further therapies (Figures 3-5). This is especially important in cases where adjuvant therapies such as radiation or chemotherapy may be required to treat skin cancer. Other situations where microvascular free tissue transfer reconstruction is beneficial include: wounds where bone, nerve, or blood vessels are exposed and must be protected; large surface areas of lost skin (usually greater than 30 cm^2); and history of prior surgeries or radiation to the wound that might prevent would healing by other means[2,3]. The facial plastic surgeons in the Department of Otolaryngology – Head and Neck Surgery all have extensive experience and fellowship training in facial reconstruction. Specifically, microvascular free tissue transfer is only performed by surgeons with further training in reconstructive microsurgery, and we are happy to provide this option to our patients to suit all their reconstructive needs.

Figure 3. Microvascular free tissue transfer reconstruction of a large scalp skin cancer. A. Skin cancer of the scalp marked for excision. B. Scalp wound after cancer removal with exposed bone demonstrated. C. Intraoperative photo showing immediate reconstructive result. D,E,F. Healing outcome three weeks post-operatively.

Figure 4. Microvascular free tissue transfer reconstruction of a large scalp and neck sarcoma. A. Cancer of the scalp and neck marked for excision. B. Wound after cancer removal with exposed bone and blood vessels. C. Intraoperative photo showing immediate reconstructive result. D,E,F. Healing outcome 10 weeks after surgery.

References:

1. Huang AT, Tarasidis G, Yelverton JC, Burke A. A novel advancement flap for reconstruction of massive forehead and temple soft-tissue defects. *Laryngoscope.* 2012;122:1679-1684.

2. Burch MBB, Chung TK, Rosenthal EL, Schmalbach CE. Multimodality management of high-risk head and neck basal cell carcinoma requiring free-flap reconstruction. *Otolaryngol Head Neck Surg.* 2015;152:868-873.

3. Desai SC, Sand JP, Sharon JD, Branham G, Nussenbaum B. Scalp reconstruction: an algorithmic approach and systematic review. *JAMA Facial Plast Surg.* 2015;17:56-66.

EDUCATION UPDATE

Pictured (L to R): Ilene Chiu, Andrew Victores, Daniel Fox, and Ramya Patel

ILENE CHIU, MD
Faculty Associate
UT Southwestern Department of
Otolaryngology – Head & Neck Surgery
Dallas/Ft. Worth, TX

DANIEL FOX, MD
Private Practice
Texas Ear Nose and Throat Specialists
Katy, TX

RAMYA SRINIVISAN PATEL, MD
Private Practice
ENT Associates of Houston – Medical Center
Houston, TX

ANDREW J. VICTORES, MD
Fellowship – Rhinology and Skull Base Surgery
John Hopkins Hospital
John Hopkins University School of Medicine
Baltimore, MA

Resident Research Day & Visiting Professor, Marion Couch, MD, PhD, MBA, FACS, Professor and Chair, Department of Otolaryngology – Head & Neck Surgery, Indiana University

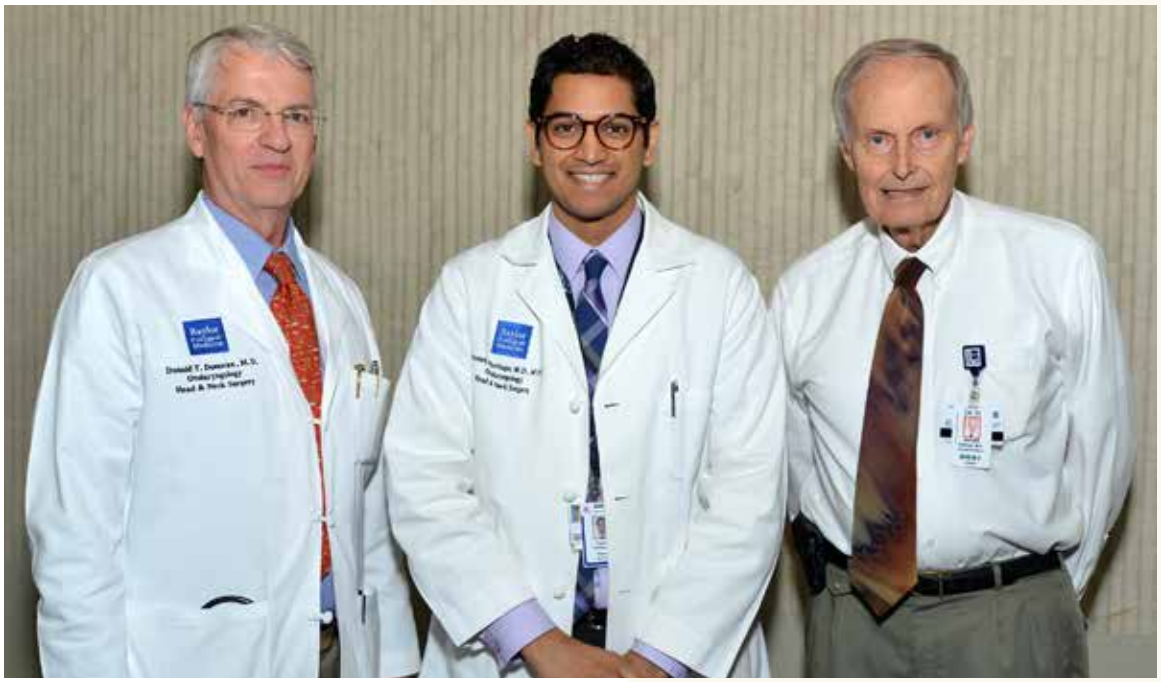
29TH ANNUAL J. CHARLES DICKSON AWARD

Dr. J. Charles Dickson was widely respected for his pioneering work in otolaryngology and was considered an authority in his field. This is the 28th year that residents in our program have been honored with the awards.

OUTSTANDING CLINICAL RESEARCH

Nathan Lindquist, MD

The Implications of Antibiotic Susceptibility for the Surgical Treatment of Neck Abscesses at a Tertiary Pediatric Care Center



OUTSTANDING CLINICAL RESEARCH

Prasanth Pattisapu, MD

A Systematic Review of Temporal Bone Trauma Causing Facial Nerve Injury: a Suggestion for Minimum Reporting Guidelines

Presented by Herbert L. DuPont, MD, MACP, President and CEO Kelsey Research Foundation on behalf of the Kelsey-Seybold Clinic and the Kelsey Research Foundation.

DR. SMITH AWARD TO ADMINISTRATIVE CHIEF

Daniel Fox, MD

2016-2017 Administrative Chief

Presented by Herbert L. DuPont, MD, MACP (pictured right) in honor of Dr. James Smith

FIRST ANNUAL EARLIE THORN AWARD – FOR JUNIOR RESIDENT DEMONSTRATING SELFLESSNESS IN SERVICE

Omar G. Ahmed, MD

Presented by Caleb Simmons, MD, Class 2016 (pictured left)
with the help of Ms. Earlie Thorn (pictured right)

Chief Resident, Ramya Patel, MD (pictured right), on behalf of her classmates, presented Donald T. Donovan, MD, FACS with this year's Faculty Teaching Award.

Rachel Regone, MD is this year's recipient of the Annual Resident Teaching Award presented by the Texas ENT Specialists.

Rance Raney, MD, class 1997, presented the award, which his group has done for the past 20 years.

RESEARCH

RECENTLY AWARDED RESEARCH FUNDING

PI	PROJECT TITLE	FUNDING SOURCE
Andrew Sikora, MD, PhD	Targeting the Immune Microenvironment to Make Tumors Susceptible to Immune Attack	Owens Foundation Translational Research Award
PI: Stephen Y. Lai, MD, PhD, FACS – MD Anderson **Co-Investigator: Vlad C. Sandulache, MD, PhD**	Using Dynamic Contrast-Enhanced Magnetic Resonance Imaging (DCE-MRI) to Establish Objective Clinical Outcome Measures for Mandibular Osteoradionecrosis	National Cancer Institute

PUBLICATIONS

1. Kahrilas PJ, **Altman KW**, Chang AB, et al. Chronic Cough Due to Gastroesophageal Reflux in Adults: CHEST Guideline and Expert Panel Report. Chest. 2016;150(6):1341–1360.

2. Zhou J, **Yu W**, Hardin PE. CLOCKWORK ORANGE Enhances PERIOD Mediated Rhythms in Transcriptional Repression by Antagonizing E-box Binding by CLOCK-CYCLE. PLoS Genet. 2016;12(11):e1006430.

3. Boulet L-P, Turmel J, Irwin RS, **CHEST Expert Cough Panel**. Cough in the Athlete: CHEST Guideline and Expert Panel Report. Chest. 2017;151(2):441–454.

4. Pile J, **Sweeney AD**, Kumar S, Simaan N, Wanna GB. Detection of modiolar proximity through bipolar impedance measurements. Laryngoscope. 2016.

5. Liao K, Blumenthal-Barby J, **Sikora AG**. Factors Influencing Head and Neck Surgical Oncologists' Transition from Curative to Palliative Treatment Goals. Otolaryngol Head Neck Surg. 2017;156(1):46–51.

6. **Rajasekharan V**, Sreenivasan VKA, **Farrell B**. Force Measurements for Cancer Cells. Methods Mol. Biol. 2017;1530:195–228.

7. **Victores AJ, Olson K, Takashima M**. Interventional Drug-Induced Sleep Endoscopy: A Novel Technique to Guide Surgical Planning for Obstructive Sleep Apnea. J Clin Sleep Med. 2017;13(2):169–174.

8. Laban S, Giebel G, Klümper N, ...**Sikora AG**, et al. MAGE expression in head and neck squamous cell carcinoma primary tumors, lymph node metastases and respective recurrences-implications for immunotherapy. Oncotarget. 2017;8(9):14719–14735.

9. Tarlo SM, **Altman KW**, Oppenheimer J, et al. Occupational and Environmental Contributions to Chronic Cough in Adults: Chest Expert Panel Report. Chest. 2016;150(4):894–907.

10. O'Connell BP, Hunter JB, **Sweeney AD**, et al. Outcomes of the Suture "Pull-Through" Technique for Repair of Lateral Skull Base CSF Fistula and Encephaloceles. Otol. Neurotol. 2017;38(3):416–422.

11. **Sweeney AD**, Hunter JB, Rajkumar SV, et al. Plasmacytoma of the Temporal Bone, a Great Imitator: Report of Seven Cases and Comprehensive Review of the Literature. Otol. Neurotol. 2017;38(3):400–407.

12. Akst LM, Haque OJ, Clarke JO, …**Altman KW,** et al. The Changing Impact of Gastroesophageal Reflux Disease in Clinical Practice. Ann. Otol. Rhinol. Laryngol. 2017;126(3):229–235.

13. Nelson C, Lee J, Ko K, …**Sikora AG**, et al. Therapeutic Efficacy of Esomeprazole in Cotton Smoke-Induced Lung Injury Model. Front Pharmacol. 2017;8:16.

CONTINUED FROM PAGE 10

PRESENTATIONS

Ahmed OG, Guillerman RP, **Giannoni CM**. Protocol utilizing Low-Dose Non-Contrast CT Airway can Decrease Bronchoscopy Rates for Suspected Foreign Bodies in Pediatric Patients. Podium Presentation at *American Society of Pediatric Otolaryngology Annual Meeting;* May 2017; Austin, Texas.

Altman KW. A practical approach to dysphagia in adults: What else besides reflux? Presented at *Texas Association of Otolaryngology Annual Meeting*; May 2017; Houston, Texas.

Altman KW. Chronic couch and the protective laryngeal mechanism. Keynote lecture at *IFOS – The ENT World Congress*; June 2017; Paris, France.

Bassett E, Aboul-Fotouh D, Hicks MJ, **Rosenberg TL**, **Chelius DC**. Pigmented epithelioid melanocytoma: a case report and review of the literature. Poster at *SETNAC;* December 2017; Orlando, Florida.

Chelius DC, Metha D, Pattisapu P. Tonsillectomy vs. Tonsillotomy: A Cost-Effectiveness Analysis. Talk at *American Society of Pediatric Otolaryngology Annual Meeting*; May 2017; Austin, Texas.

Cohen HS, Stitz J, Mulavara AP, Peters BT, Miller C, Sangi-Haghpeykar H, Williams SP, Bloomberg JJ. Updated norms for epidemiologic screening tests of the vestibular system. Poster at *Association for Research in Otolaryngology Mid-Winter Meeting;* February 2016; San Diego, California.

Druck Santa Anna G**, Altman KW**. Benign vocal fold lesions and phonosurgery: nomenclature. Presented at *Texas Association of Otolaryngology Annual Meeting*; May 2017; Houston, Texas.

Farrell B, Bengstom J. Data Management Plan to Curate Electrophysiological Data From The Mammalian Cochlea. Presented at *40th Annual Meeting of Association of Research in Otolaryngology;* February 2017; Baltimore, Maryland.

Farrell B, Rajasekharan V. Adaptive Analysis of the Motor Force measured at the Plasma Membrane of a Cancer cell. Presented at *Gordon Research Conference Physical Science of Cancer;* February 2017; Galveston, Texas.

Frisch CD, Patel A, **Vrabec JT**, **Sweeney AD**. Diffuse Hyperostosis of the Skull Base. *North American Skull Base Society Meeting;* 2017; New Orleans, Louisiana.

Hanoteau AC. Overcoming T cell radio-sensitivity and exploiting radiation-induced lymphopenia to enhance cancer therapy? Poster presentation at *Annual Dan L Duncan Comprehensive Cancer Center;* March 2017; Houston, Texas.

Mohyuddin N, Yim M, Bennet B. Horse Bite Crush Injury to the Larynx: A Case Report. Poster Presentation at *Combined Otolaryngology Spring Meetings*; April 2017; Sand Diego, California.

Mohyuddin N, Chiu I, Ali O. Hepatocellular carcinoma with nasal metastasis. Poster Presentation at American Academy Meeting;

Pattisapu P, Carlson ML, Gresham M, McElwee T, **Vrabec, JT**, **Sweeney, AD**. A Systematic Review of Temporal Bone Trauma Causing Facial Nerve Injury: a Suggestion for Minimum Reporting Guidelines. Oral presentation at *Triological Society Annual Spring Meeting;* 2017; San Diego, California.

Richards T, Clark S, Garber S, **Cohen HS**, Wong SJ. Nurturing the Prepared Mind: An Exploratory Study on Research During Level II Fieldwork. Poster at *American Occupational Therapy Association Annual Meeting;* May 2017; Philadelphia, Pennsylvania.

Rajasekharan V, Sreenivasan VKA, Myers JN, **Pereira FA, Farrell B**. Catch-slip behavior of membrane-cytoskeleton bonds in cancer cells in Rho-mediated. Presented at *61st annual meeting of the Biophysical Society;* February 2017; New Orleans, Louisiana.

Rappleye E, Moss J, Stock G, **Altman K**, Chisley G. Great physician relationships in mid-sized markets. Presented at *Becker's Hospital Review 8th Annual Meeting*; April 2017; Chicago, Illinois.

CONTINUED FROM PAGE 11

Sweeney AD, O'Connell B, Tombers NM, Patel NS, Wanna GB, Carlson ML. Types of Canal Dehiscence Into the Superior Petrosal Sinus. Oral Presentation at *American Academy of Otolaryngology – Head and Neck Surgery Annual Meeting and OTO EXPO*; 2017; Chicago, Illinois.

Sweeney AD, Hunter JB, Rajkumar SV, Lane JI, Jevremovic D, Carlson ML. *Plasmacytoma of the Temporal Bone: Report of 7 Cases and Comprehensive Review of the Literature*. Triological Society Combined Sections Meeting; 2017; New Orleans, Lousiana.

Takashima M. Invited lecturer and moderator at *International Surgical Sleep Society*; May 2017; University of Southern California, LA, California.

Vilela RJ. Improved Contralateral Hearing after Unilateral Cochlear Implantation in a Child with Auditory Neuropathy Spectrum Disorder. Poster at *15th Symposium on Cochlear Implants in children (CI2017);* July 2017; San Francisco, California.

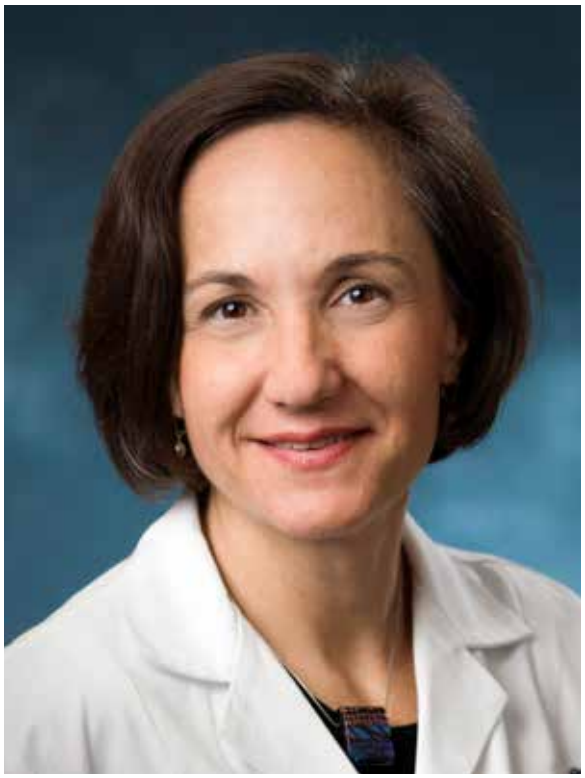
Wilde DC, Breen JT, **Frisch CD**, Duckworth EA, **Sweeney AD**. *Colon Cancer Metastasis to the Lateral Skull Base Masquerading as Mastoiditis*. North American Skull Base Society Meeting; 2017; New Orleans, Louisiana.

DR. BERT W. O'MALLEY JR. PRESENTED AS THE BOBBY R. ALFORD DISTINGUISHED LECTURE ENDOWED BY THE HELIS FOUNDATION.

L to R: Dr. Donald T. Donovan, Dr. Bobby R. Alford, and Dr. Bert W. O'Malley Jr.

AWARDS AND HONORS

Daniel C. Chelius, Jr., MD
Councilor, BCM Alpha Omega Alpha
AAO-HNS Ethics Chair Search Committe



Carla M. Giannoni, MD
President-elect for the Texas Children's Hospital – January 2018

Tara L. Rosenberg, MD
Selected as Surgical Director of the Texas Children's Hospital Vascular Anomalies Center

Andrew G. Sikora, MD, PhD
Invited to join the Research Committee of the American Head and Neck Society

Picture 2

TEXAS CHILDREN'S HOSPITAL – KATY AND THE WOODLANDS

DEIDRE R. LARRIER, MD
Texas Children's Hospital

This spring, Dr. Deidre Larrier at Texas Children's Hospital conducted three-simulation training exercises at Texas Children's sister hospitals in Katy and The Woodlands. TCH Katy had experienced a turnover in operating room staff and expressed an interest in having them retrained in the management of aerodigestive foreign bodies. We met that need with a three-hour training session where the first half introduced the topic and the instruments we used (picture 1), while the second half immersed

Picture 1

Picture 3

them in two scenarios where they had to retrieve aerodigestive foreign bodies (picture 2).

Prior to the opening of the operating room at our new TCH in The Woodlands, we completed similar training session in aerodigestive foreign bodies (picture 3) for operative and peri-operative staff, as well as in the evaluation and management of post tonsillectomy bleeds for the surgical advanced practice providers who will be working with the Otolaryngology service there.

Special thanks to Dr. Mary Musso (West Campus) and Dr. Sonal Soraiya (TheWoodlands) for co-teaching in these exercises.

Baylor College of Medicine

BOBBY R. ALFORD DEPARTMENT OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY

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