WHAT YOU OTO KNOW

THE UNIVERSITY OF VIRGINIA
DEPARTMENT OF OTOLARYNGOLOGY-
HEAD AND NECK SURGERY

SPRING 2022
VOL. 3, NO. 1

RESIDENT LIFE

An interview with our chiefs on their residency experience and next steps

DIVISION PEARLS

Clinical pearls explored by faculty & residents

ALUMNI NEWS

Stay up-to-date on the latest news from our alumni in our newest feature

UNIVERSITY of VIRGINIA

Department of Otolaryngology-Head and Neck Surgery

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What You Oto Know is a biannual newsletter published by The University of Virginia Department of Otolaryngology-Head and Neck Surgery.

Please send questions, comments and requests for hard copies to Chelsey Jankowski, cen7b@virginia.edu

What You Oto Know
Spring 2022 VOL. 3, NO. 1

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Don't forget to follow us on social media @uvaotohns

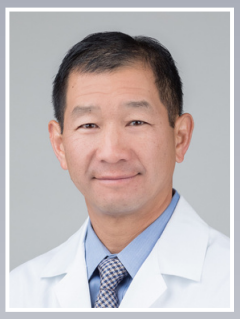
NEWS & FEATURES

LOCATIONS

- UVA Health
- ENT Clinic at Fontaine
- Emily Couric Clinical Cancer Center
- Pediatric Oto Clinic at the Battle Building
- Charlottesville ENT Associates
  (Not pictured)

FACULTY

Facial Plastic & Reconstructive Surgery



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Associate Professor

Rhinology & Endoscopic Sinus Surgery

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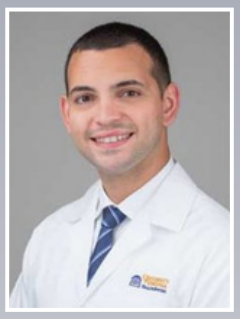

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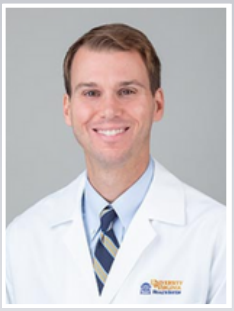

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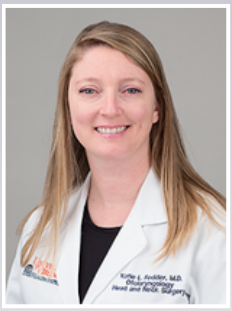

Katherine Fedder, MD
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Jonathan Garneau, MD
Assistant Professor

Eric Dowling, MD
Assistant Professor
Joining Summer 2022

Laryngology & Voice Care

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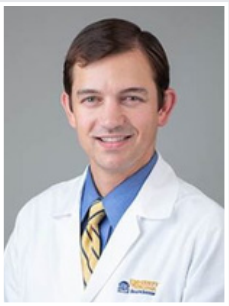

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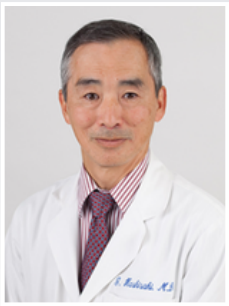
Assistant Professor

Otology & Neurotology



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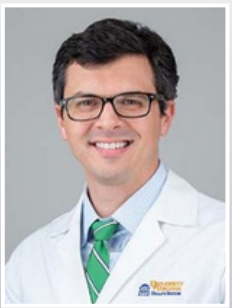
Associate Program Director,
Professor

Pediatric Otolaryngology



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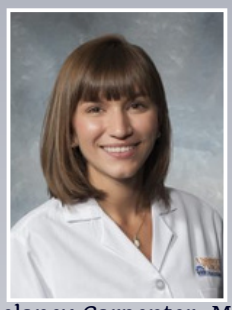
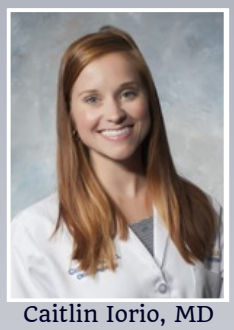

Delaney Carpenter, MD


Ian Churnin, MD


Caitlin Iorio, MD

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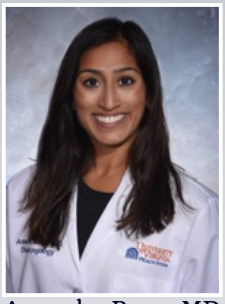
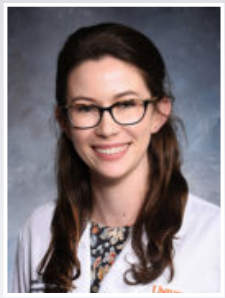

Annesha Basu, MD


Rachel Jonas, MD


Neil Saez, MD

PGY3

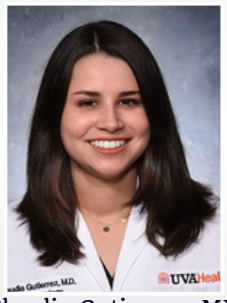

Simone Barker, MD


Hyunseo"David" Jung, MD


Jeffrey Mella, MD

PGY2

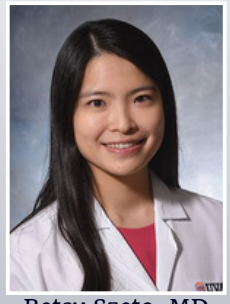

Nelson Gruszczynski, MD

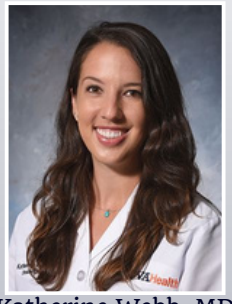

Claudia Gutierrez, MD


Christopher Harryman, MD

PGY1


Kent Curran, MD


Betsy Szeto, MD


Katherine Webb, MD

FELLOWS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Otology / Neurotology Fellow


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Facial Plastic & Reconstructive Surgery Fellow


Osama Hamdi, MD
Research Fellow

Absorbable vs Permanent Suture Closure During Open Rhinoplasty: No Cosmetic Difference In Scar

DIVISION: FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Rhinoplasty is a commonly performed surgery to improve nasal breathing, nasal appearance, or both. Many factors affect the decision to perform rhinoplasty via an endonasal or open approach, but one of these is often the creation of a scar across the columella. When performing an open approach, surgeons commonly use permanent skin sutures to close the columellar incision to minimize scar formation, but this can cause patient discomfort during removal. Surgeons may be hesitant to use absorbable sutures during rhinoplasty due to concerns for increased inflammation and worse scar appearance.

We recently completed a prospective, randomized-control trial to objectively determine if there was a difference in cosmetic outcome between an absorbable and permanent suture for columellar closure. Sixty patients were randomly allocated to closure with either a permanent 6-0 Prolene suture or absorbable 5-0 fast absorbing gut suture. Six and twelve-month scar outcomes were assessed by physicians blinded to the suture material using the validated Stony Brook Evaluation Scale (SBES). Patients also evaluated their scar appearance using the Patient Scar Assessment Questionnaire (PSAQ) at the same time points. There was no statistical difference in scar appearance between the two suture types. Patients with permanent sutures rated the pain of suture removal as an average of 4.88 on a 0-10 scale. Despite these findings, we experienced a higher-than-expected attrition rate and fell just short of meeting the required sample size for final analysis. While no difference was seen between groups in our cohort, we could not exclude a meaningful difference in outcomes within a larger sample.

SBES and PSAQ for absorbable and non-absorbable sutures

	Mean (SD)			
	Absorbable Suture	Non-absorbable Suture	U	p
SBES†	4.043 (0.82)	3.97 (0.92)	203.5	0.93
PSAQ‡	31.62 (6.56)	30.2 (4.78)	138.5	0.54

†Stony Brook Evaluation Scale

‡Patient Scar Assessment Questionnaire

Using the Mann–Whitney U test, we did not detect a difference in cosmetic patient-reported outcomes (PSAQ) between the two groups. Furthermore, there was no superiority in either suture type for blinded observer outcomes (SBES).

Highest (a and c) and lowest (b and d) SBES outcomes for columellar scars observed at the 12-month postoperative visit for closure with 5–0 fast absorbing plain gut (a and b) and with 6–0 polypropelene (c and d). A higher SBES represents better blinded observer scar evaluation. (a) Closure with 5–0 fast absorbing plain gut with SBES of 5 by each blinded reviewer. (b) Closure with 5–0 fast absorbing plain gut with SBES scores of 2 and 3 by blinded reviewers. (c) Closure with 6–0 polypropelene with SBES score of 5 by each blinded reviewer. (d) Closure with 6–0 polypropelene with SBES score of 2 by each blinded reviewer. SBES, Stony Brook Evaluation Scale. A higher SBES represents better blinded observer scar evaluation.

To further investigate our conclusion, we performed a systematic review and meta-analysis of six studies, including our own, that evaluated permanent and absorbable suture closure during open rhinoplasty. Four studies were retrospective and two were prospective with a total of 435 patients. There was no significant difference in scar appearance between the absorbable suture group and nonabsorbable group among both patient-reported and physician-measured outcomes.

There is no difference in columellar scar appearance with absorbable versus permanent sutures in open rhinoplasty. This can save time and patient discomfort by avoiding the need for suture removal during post-operative clinic visits.

RACHEL JONAS, MD PGY-4
SAM OYER, MD ASSOCIATE PROFESSOR

 See Page 14 for References

Smell Loss and Smell Retraining for COVID-19

DIVISION: RHINOLOGY & ENDOSCOPIC SINUS SURGERY

Early in the COVID-19 pandemic, alteration in smell was recognized as a common presenting symptom for this disease. In fact, in many cases this can be the primary or sole presenting symptom. The pathophysiology behind smell loss due to COVID-19 is not well understood, and possible mechanisms include direct injury to the neuroepithelium, edema of the sinonasal cavity and olfactory cleft, neuropathy, and possible central effects. Nonetheless, estimates of the incidence of smell loss in patients with COVID-19 range from 40 to 90% depending on the population being studied. The rate of smell recovery in these patients ranges from 40 to 85%. Most patients experience recovery within 60 days, but recovery can be seen 6 months or later after infection.

Despite the wide range of smell dysfunction and rates of recovery in the literature, one thing is certain: a large number of COVID-19 patients have smell dysfunction that can last for many months after infection and in some cases may be permanent. These patients report a variety of ways in which smell dysfunction can impact their quality of life. In the mildest cases, patients report decreased enjoyment of food and drink and inability to enjoy scents that previously brought joy to their lives. In severe cases, these patients can report a severe aversion to foods or previously pleasant smells (parosmia), concerns over safety (due to their inability to smell smoke, gas leaks, rotten food, etc.), and in unfortunate cases patients report phantom smells that significantly impact their lives and the lives of those around them.

Even though significant research is ongoing on ways to improve the smell function of these patients, treatment options remain limited. To date, the most effective therapy for smell

Researchers have attempted to categorize the many different smells that humans are capable of detecting. These categories include floral, fruity, spicy, resinous, burnt and foul. SRT focuses on the first four categories.

restoration is smell retraining therapy (SRT). SRT is an intervention that takes advantage of the innate ability of the olfactory neuroepithelium to heal and regenerate. SRT utilizes essential oils with well-known scents to re-train the olfactory system. There are a variety of online resources and regimens available, but the classic regimen involves smelling clove, lemon, eucalyptus, and rose each for 15 seconds, twice a day. Training is typically completed over 3-6 months, but patients are counseled that smell recovery can take 12 months or longer. A number of studies have demonstrated the effectiveness of SRT when smell loss is caused by viruses, such as in the case of COVID-19. The addition of topical or oral corticosteroids may also be beneficial in combination with SRT therapy. **COVID-19 is associated with anosmia in 40-90% of patients, with variable recovery. SRT can be used to aid in restoration of smell in these patients, with the consideration of topical or oral corticosteroids.**

JOSE MATTOS, MD, MPH
PROGRAM DIRECTOR, ASSISTANT PROFESSOR

 See Page 14 for References

Thoracoacromial Artery Perforator Flap

DIVISION: HEAD & NECK ONCOLOGIC & MICROVASCULAR SURGERY

Over the past several decades, head and neck surgery has made significant strides in both ablative and reconstructive techniques. Within the realm of reconstructive surgery, patients undergoing major ablative head and neck surgery typically undergo immediate reconstruction in the form of locoregional or free tissue transfer. Nowadays, it is quite common for patients to undergo free tissue transfer (free flap surgery) when a significant defect is anticipated. However, locoregional or "rotational flaps" still play a major role in head and neck reconstruction.

For instance, not all patients are ideal candidates or well suited for free flap surgery. This may be due to significant medical comorbidities that may impact the success rate of free tissue transfer or add substantial risk to a lengthened inpatient hospital stay. As reconstructive surgeons, we also must consider the consequences of the "donor site", which may significantly limit a patient's mobility, activity level, particular hobbies, work performance, or manual dexterity, all important considerations for a patient's quality of life. Therefore, in select cases, a rotational flap may be preferable to free tissue transfer to achieve the same functional and aesthetic outcome after major ablative head and neck surgery.

Within advanced reconstructive surgery, there has been a shift towards the development and description of "perforator based" flaps as our understanding of the micro-anatomical basis of how various regions of graft harvest sites can be supplied by single "perforators" or small caliber vessels originating from larger (named) vessels. The most common example of perforator based flaps that have made significant modifications over the years is the anterolateral thigh or "ALT" free flap. After its initial description in the literature, the ALT flap has been further modified as our anatomical understanding has increased.

During the current technique of an ALT flap harvest, the first step is usually aimed at identifying a obvious skin perforator that is then traced to its take off from the lateral circumflex arterial system which has a variable origin. Despite its variability, as long as a perforator is identified and traced to a larger caliber vessel, free flap transfer can proceed regardless of the origin. Such perforator based harvests of free flaps have been able to be applied to other areas and "push the envelope" for what can be achievable based on various perforator regions throughout the rest of the body.

A newer described example of this concept is a recent perforator based rotational flap called the thoracoacromial artery perforator flap (TAAP). This is the perforator concept applied to the traditional pectoralis major flap or "Pec Flap". In our current era, the pectoralis major myocutaneous flap is still a major workhorse for head and neck reconstruction. The pectoralis major flap is based off of the pectoral branch of the thoracoacromial arterial system which has its proximal origin from the axillary artery.

However, in recent literature there has been increased use of the thoracoacromial artery perforator flap, which takes advantage of the "perforator based" concept and allows the harvest and rotation of a fasciocutaneous flap (just skin and subcutaneous tissue) without the underlying pectoralis muscle to repair limited defects of either the hypopharynx, larynx, or other structures in the lower 2/3 of the neck. This new concept identifies a reliable perforator to a region of skin and subcutaneous tissue in the pectoralis region that can easily be rotated and transferred to the ablative defect.

A major advantage of this particular flap is that there is reduced bulk of the tissue being

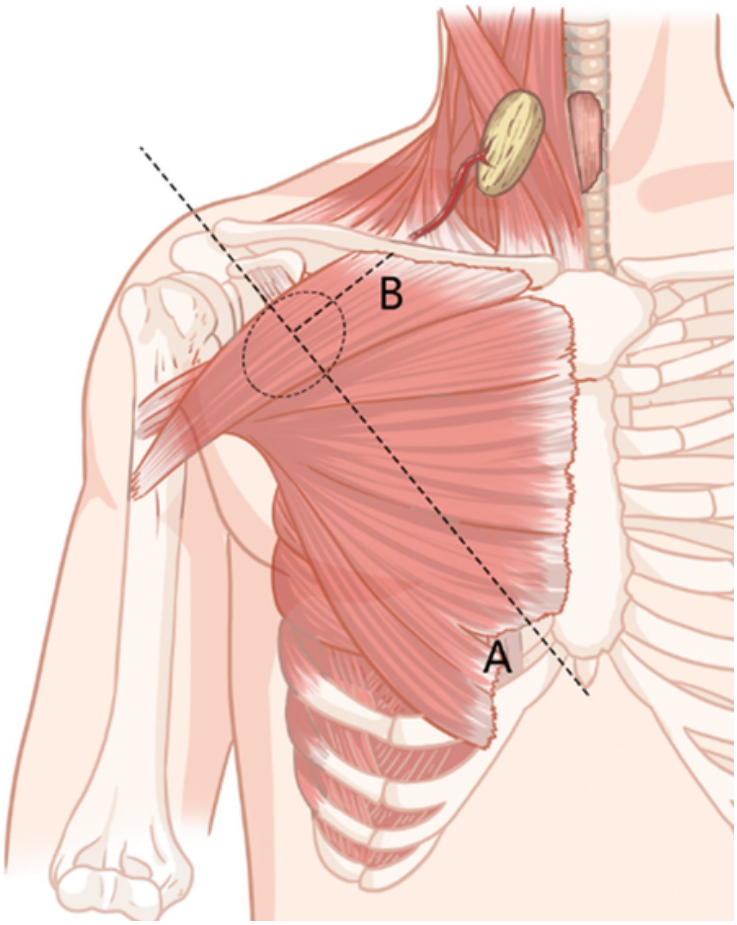
 See Page 14 for References

transferred. The pectoralis major muscle is not included in the flap or disrupted from its origin and insertion, which preserves full function. Furthermore, harvest of the thoracoacromial artery perforator flap does not disrupt the vascular supply to the pectoralis muscle, therefore preserving the ability to transfer a traditional pectoralis major flap in the future.

We would like to present a case example of a patient who underwent reconstruction with a TAAP flap. We had a case of a 62-year-old male a large level II-IV neck mass positive for squamous cell carcinoma with involvement of the internal jugular vein and lower 1/3 of the sternocleidomastoid muscle. Based on the anticipated defect with planned adjuvant radiotherapy, it was recommended he undergo reconstruction with either free tissue transfer or locoregional flap. We reconstructed the defect with a thoracoacromial artery perforator flap.

The TAAP flap is designed based on the axis between the acromion and xiphoid process where a perpendicular line is drawn from the mid-clavicular region and a perforator is identified with a handheld Doppler within a 4sq cm region (see figure 1). In our situation, we chose to harvest a 6 x 12cm fasciocutaneous flap based on the axis of our perforator and amount of tissue required.

The flap was harvested by making the medial aspect of the incision first, through the skin and subcutaneous tissue. Then the incision is taken through the pectoralis fascia. Once the pectoralis fascia is incised, a sub-fascial dissection is performed in a medial to lateral fashion with care to identify the dominant perforator or perforators emanating from a consistent septum in the pectoralis major muscle. Robust perforators are seen emanating from this muscular septum between the clavicular and sternocostal heads of the pectoralis major muscle, supplying the fasciocutaneous region. Once the perforators are identified, the rest of the skin incisions can be made and adjusted if a dominant perforator is seen in a slightly unexpected location in relation to the skin Doppler site. In our scenario, our Doppler site was accurate and we were able to complete the circumferential incisions of the proposed design without any modification.



Once our flap was islanded on its selected perforator, a subcutaneous tunnel in the supraclavicular region was made and the flap was de-epithelialized and rotated into the sternocleidomastoid defect to provide coverage of the common carotid artery and obliterate the defect. The flap was able to rotate without any tension on the vascular pedicle and minimal dissection was required to achieve optimal reachto the defect. The donor site in the pectoralis region was closed primarily after undermining on either side. The patient achieved an excellent reconstructive outcome with minimal donor site morbidity and a brief hospital stay.

The TAAP flap can be used for reconstruction of lower neck defects without the morbidity of the pectoralis muscle flap or free tissue transfer.

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 See Page 14 for References

Direct Laryngoscopy: Troubleshooting a Difficult Exposure

DIVISION: LARYNGOLOGY & VOICE CARE

PATRICK MCGAREY JR. , MD
ASSISTANT PROFESSOR

Suspension microlaryngoscopy is an essential technique which allows for diagnostic and therapeutic intervention of laryngeal and tracheal pathology. Due to a variety of factors, some patients may have difficult laryngeal exposure which complicates management.

Most otolaryngologists utilized the Dedo laryngoscope, whose profile may make it more challenging to obtain adequate anterior exposure in some patients.The anterior commissure scope can improve anterior exposure compared to the Dedo, however it only allows for monocular vision, and thus cannot be utilized adequately with a microscope.The Ossoff-Pilling laryngoscope is ideal for exposing difficult laryngeal anatomy, due to its narrower contour but preserved ability for binocular vision.

Certain operating room headboard and headrest configurations will not allow for optimal head extension and neck flexion required during difficult exposures.Occasionally the headrest needs to be removed and the neck significantly flexed (Figure 1). The laryngoscope will then be awkwardly oriented unless the patient is placed in Trendelenburg position in order to lower the angle of approach through the laryngoscope.

Additionally, cricoid taping can allow for improved exposure of the anterior larynx. Silk tape is placed at the superior most aspect of the headboard on the bed and then brought inferiorly to lie over the cricoid. A 4x4 gauze is folded and used to provide additional pressure at the location which yields optimal laryngeal exposure. The tape is then secured to the opposite side of the table at the superior most aspect of the headboard (Figure 2). It can be helpful to use a non-stick surface for placement of laryngeal suspension (Cord Alert, used for OR electrical cord protection) as the suspension can often slightly slip out of place due to the significant tension needed for these difficult exposures (Figure 3).

In extreme cases, the larynx can be examined and pathology addressed using an angled telescope (30 or 70 degree) coupled with angled microlaryngeal instruments. This will often require an assistant holding a telescope in place while angled instrumentation is used to address pathology. **You can utilize patient positioning, taping, and angled telescopes to improve exposure during direct laryngoscopy.**

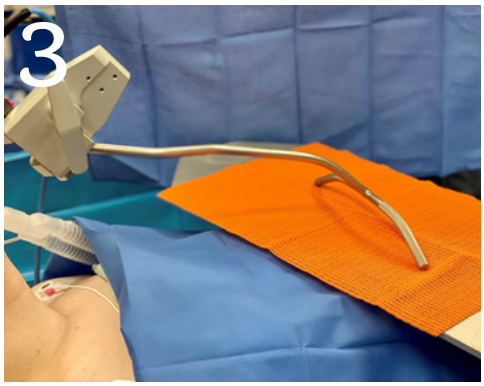


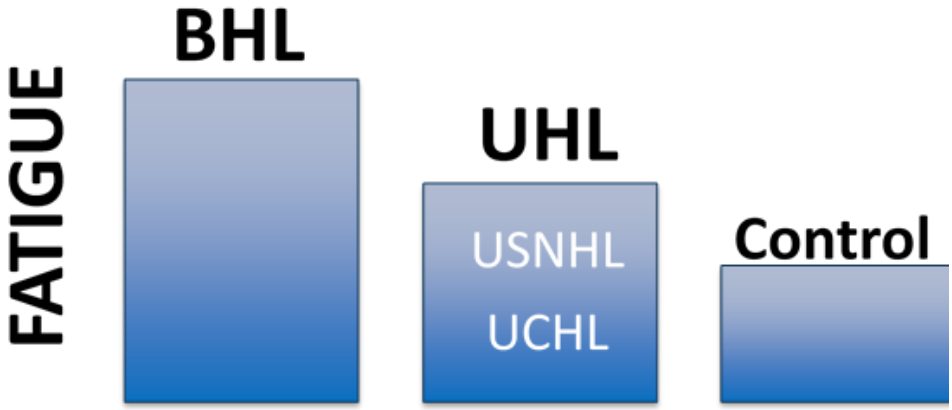
Figure 1. Headrest is removed so head extension and neck flexion can be maximized. The bed will need to be placed in Trendelenburg position to allow for a shallower angle of the laryngoscope for surgery.
Figure 2. Cricoid taping technique, to improve anterior laryngeal exposure.
Figure 3. Non-stick surface for laryngeal suspension, useful in preventing slippage of the laryngoscope/suspension unit when under the significant tension needed for difficult laryngeal exposures.

 See Page 14 for References

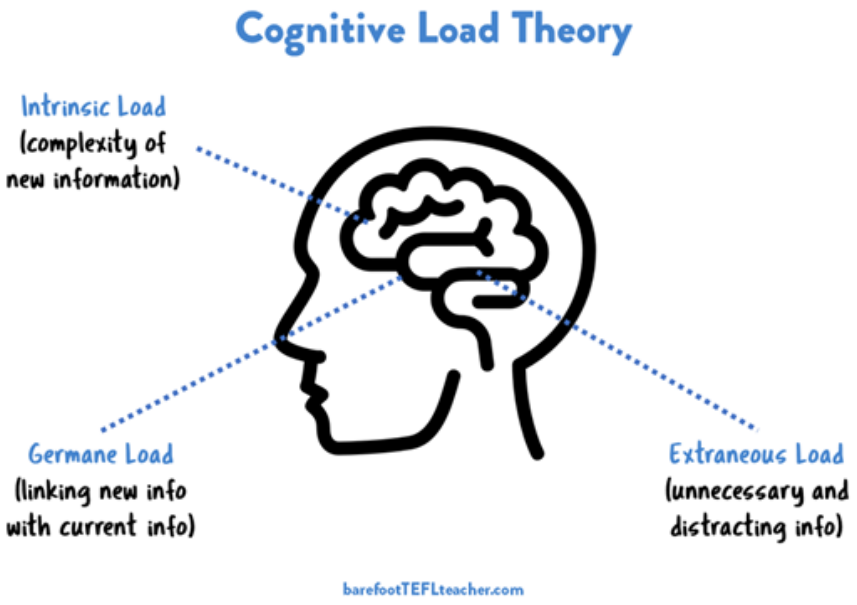
Rest is Best for Children with Hearing Loss

DIVISION: OTOLOGY & NEUROTOLOGY

Everyone needs a good night's sleep, and no group needs sleep more than children. Now, a recently published study from the UVA Department of Otolaryngology shows that children with hearing loss need sleep even more than their normal hearing counterparts.



Using a Pediatric Quality of Life Multidimensional Fatigue Survey (Peds QL MFS) assessing normal hearing children and children with hearing loss and their parents, Drs. Kesser and current Chief resident Delaney Carpenter, in partnership with a group from Washington University in St. Louis led by Dr. Judith Lieu, showed that children with bilateral hearing loss (BHL) report greater levels of fatigue than normal hearing (control) children and, interestingly, greater levels of fatigue than children with unilateral hearing loss (UHL). In addition, children with unilateral hearing loss report greater levels of fatigue than normal hearing children.



The authors postulate that hearing loss creates a larger cognitive load, the total information the brain must process in its working memory, on children and results in greater fatigue as these children make their way through their school day.

These findings underscore the need to increase auditory rehabilitation and educational resources for children with hearing loss and support the use of the PedsQL MFS questionnaire as a measure to follow disability experienced by children with HL as they undergo hearing rehabilitation.

Children with hearing loss report greater levels of fatigue than normal hearing children, with BHL children reporting the greatest level of fatigue. We clinicians should screen children with hearing loss for sleep disturbance. The importance of sleep and quiet time for these children should be stressed.

BRADLEY KESSER, MD
VICE CHAIR, ASSOCIATE PROGRAM DIRECTOR & PROFESSOR

 See Page 14 for References

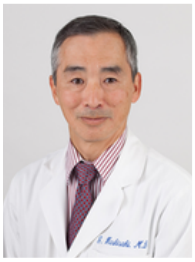
Tinnitus: The Ins and Outs of Patient Care

DIVISION: OTOLOGY & NEUROTOLOGY

Main Highlight of the Division

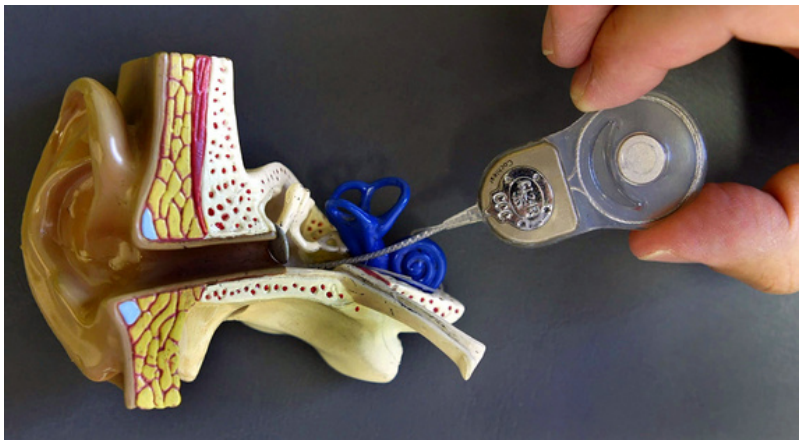
Can enter just s brief summary of the Division highlighted pearl. This could be the key research, surgery, etc. Keep it short and sweet.

This is just filler to that the page looks more like how it would after a few sentences are written. Hopefully they can do this in a paragraph or two. Should be more like an abstract of the pear of the department. A great way to mitigate the need to write a lot and you can highlight key areas. Could also include links or QR codes to access more detailed information on the highlighted pearl.



Interview on Tinnitus (Secondary Pearl)

Dr. Kesser recently had an interview with Katie Couric Media in which he went into a deep discussion about Tinnitus: What it is, how it presents, and possible ways to deal with the symptom of Tinnitus once you have it. The video of the interview can be access via the QR code.



Cochlear Implants Success (Secondary Pearl)

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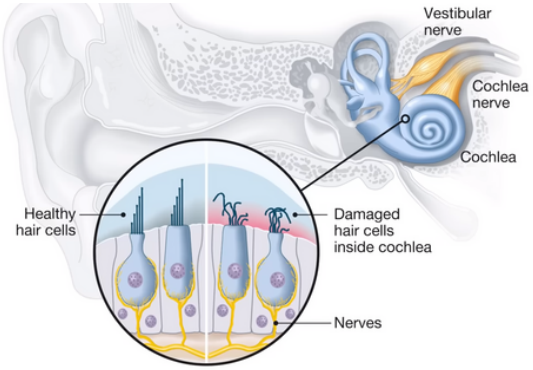

BRADLEY KESSER, MD
VICE CHAIR, ASSOCIATE PROGRAM DIRECTOR & PROFESSOR

 See Page 14 for References

The Changing Landscape of Tonsil Surgery

DIVISION: PEDIATRIC OTOLARYNGOLOGY

Coblation tonsillotomy - Preoperative

Coblation tonsillotomy - Postoperative

Adenotonsillectomy is one of the most common surgical procedures in the United States, with over 289,000 ambulatory procedures performed annually in children <15 years of age. *(1)* Sleep disordered breathing (SDB) is the primary indication for surgery in two-thirds of these cases. *(2)*

Traditionally, tonsillectomy has been the first line of treatment for pediatric SDB. Tonsillectomy involves an extracapsular dissection and en bloc resection of the tonsil. This is associated with significant postoperative pain, bleeding, and dehydration. Rates of primary (<24h postop) and secondary postoperative hemorrhage are typically quoted in the literature as 1-4%. Up to 6% of patients require readmission for postoperative complications, typically dehydration and poor pain control. *(3)*

For patients with SDB, tonsillotomy, also known as partial tonsillectomy or intracapsular tonsillectomy, is an option for treatment. Tonsillotomy involves removing only part of the tonsil, typically about 95%, using powered instruments such as the coblation wand or microdebrider. A rim of tonsil tissue is left along the pharyngeal constrictors to function as a biologic dressing. This decreases the associated pain following tonsillectomy, which is attributed to thermal injury to the pharyngeal constrictors.

Additionally, this biologic dressing helps protect the underlying musculature until mucosalization occurs, and thus decreases the risk of delayed postoperative hemorrhage. In one retrospective population-based study of 35,060 pediatric patients, the rate of postoperative hemorrhage following tonsillotomy was 0.6% compared to 2.5% in the tonsillectomy group. Similarly, the rate of readmission among tonsillotomy patients was only 1.8% compared to 4.7% of tonsillectomy patients. *(4)* There is a risk of tonsillar regrowth following tonsillotomy, which occurs approximately 3% of the time. *(5)*

Here at UVA, we offer our patients and their families shared decision making when it comes to choosing surgery for SDB. For our tonsillotomies, we use the coblation technique which allows us to operate with reduced heat (30-70˚F), but with similar or improved hemostasis compared to the traditional tonsillectomy performed with monopolar cautery. **Tonsillotomy is a new technique in the otolaryngologist's armamentarium that offers improved postoperative pain control, decreased rates of delayed hemorrhage, and earlier return to normal oral intake for pediatric patients with sleep disordered breathing. There is a risk of tonsillar regrowth, ~3%, for which patients must be monitored postoperatively.**

ARIANA GREENWELL, MD
ASSISTANT PROFESSOR

 See Page 14 for References

Pediatric Audiology at UVA

DIVISION: AUDIOLOGY / VESTIBULAR & BALANCE CENTER

The UVA Pediatric Audiology Clinic (PA) serves children of all ages with severe language delay or behaviors prohibiting use of traditional testing paradigms. Do these children have hearing loss or lack responsiveness to sound due to their developmental delay or other diagnoses such as autism? Many have been previously evaluated, but accurate testing was not realized, thus prompting referral for sedated auditory brainstem response (ABR) assessment for hearing prediction.

ABR testing, an objective measure of peripheral auditory function historically useful in the diagnosis of hearing loss in young children, requires a sleeping or sedated child. Parents express reluctance proceeding to a sedated ABR given the inherent perceived risks of sedation. With parental reluctance in mind and the desire to use OR time efficiently, our team created the PA clinic to address the needs of these children.

Within our team, we have two pediatric audiologists highly skilled in assessing this challenging population, Melissa McNichol, Au.D., and Debra Hildebrand, Au.D. Conjoined in this specialized clinic, they blend their talents - one in the sound booth with the child, and the other operating the equipment. Each appointment presents an opportunity to think outside the box, incorporate unconventional assessment techniques, and most importantly, meet the child where they are. It is not unusual to encounter resistance from the child, fearful and combative behaviors, and children absorbed thoroughly in their internal narrative.

These audiologists possess a strong foundation and an innate understanding of behavior modification techniques with principles based in operant conditioning theory. With this knowledge, perseverance, will, and steely determination, they expertly calm the child, assess skill level, offer stimuli and shape response behavior, then reinforce the behavior with a continuous schedule of positive reinforcement.

Pictured left to right are UVA Pediatric Audiologists Debra Hildebrand, Au.D. and Melissa McNichol, Au.D.

Because of the creative and concerted efforts of these two, our clinic has seen a significant decrease in the number of children referred for sedated ABR testing as reliable behavioral test results are now achievable. Parents are provided a sense of relief as sedation is no longer needed, but more so, it provides parents with the opportunity to witness first-hand their child's responsiveness to sound thus alleviating their own concerns for hearing loss. **The UVA Pediatric Audiology Clinic offers specialized two-tester audiologic evaluations for children with hearing concerns, decreasing the need for sedated ABRs.**

DEBRA HILDEBRAND, AU.D.
PEDIATRIC AUDIOLOGIST

 See Page 14 for References

RESEARCH UPDATE

Research Fellowship

The University of Virginia Department of Otolaryngology –Head & Neck Surgery is pleased to announce an opportunity for medical students or recent MD graduates seeking 12 months of specialized research training. Through the mentorship from our committed faculty, the Fellow will gain invaluable experience leading novel projects that align with their area(s) of interest and help to support ongoing departmental research projects. The overall goal of this program is for the Fellow to develop: foundational knowledge and principles of study design, conduct, and data analysis; exposure to different otolaryngologic and research disciplines; and expertise supporting an academic career in otolaryngology. Visit our website to learn more. https://med.virginia.edu/otolaryngology/research/fellowship/

Congratulations Dr. Hamdi!!!

A big congratulations to Dr. Osama Hamdi, our current research fellow, for matching into his top choice at the University of Colorado for residency. Such an excellent match couldn't have been made for a more deserving applicant. Dr. Hamdi came to us last June after completing his medical education at Howard University and quickly became an invaluable member of our research team and UVA Otolaryngology family. Dr. Hamdi was so eager to engage in the research process that he began to work remotely before he even stepped foot on grounds. He led projects ranging from a database review of vaccine-associated vocal fold paralysis to an animal model of intubation injury. We wish him the best of luck in residency and look forward to following what we know will be an impressive career as an Otolaryngologist-Head and Neck Surgeon.

Of his experience, Dr. Hamdi writes, "I had the privilege of being the first research fellow at the University of Virginia, Department of Otolaryngology- Head and Neck Surgery. Having come from a medical school without an Otolaryngology program, this experience has allowed me to cultivate a deeper understanding and greater appreciation for the field. It has also given me a better perspective on the day-to-day function of an Otolaryngologist and helped me build the skillset and dedication required to be successful. I was able to perform both clinical and translational research with some of the brightest surgeons in the nation. These valuable skills such as formulating questions, performing statistical analysis, and technical writing will serve me well as an aspiring surgeon-scientist. Lastly, the mentorship and support the department has given me has been invaluable in allowing me to move closer towards my dream of becoming an Otolaryngologist."

INTERNAL RESEARCH FUNDING

ROBERT W. CANTRELL MD, RESEARCH GRANT / PAUL A. LEVINE, MD RESEARCH GRANT

Objective- To support innovative basic science, translational and clinical research by residents and faculty. To support worthy proposals that were not selected for funding by external mechanisms. One award cycle per year providing 2 grants up to $8,000 each.

SUBINOY DAS OTORHINOLARYNGOLOGY INNOVATION GRANT PROGRAM

Objective- To foster translational research partnerships linking medicine, law, regulatory governance, and business disciplines to provide immersive faculty and resident-driven product development experiences early in an Otolaryngologist's career. One award cycle per year providing 1-2 grants up to $10,000 total.

The Miller Family Resident Education Fund

Objective- to support higher training for residents and junior faculty in the area of Facial Plastic Surgery, especially facial trauma.

Farewell Dr. Jameson

Mark J. Jameson, MD, PhD, wrapped up an illustrious tenure here at UVA this December. Mark spent nine years at MUSC where he received his MD and PhD in Cell and Molecular Pharmacology. He joined us in 2002 for his residency, and after a year away at his Head & Neck fellowship in Iowa, returned as a faculty member in 2007. For 8 years he served as a dedicated Head & surgeon under Paul A. Levine, MD, and then in 2014 was named the director of the division. He has countless accomplishments while here at UVA, but the two most notable are jump starting a research program in the department that included significant funding, interdisciplinary collaboration, several clinical trials in H&N, and an outpouring of meaningful publications. The second is creating, from nothing, the microvascular free flap program within the department. Today the program is robust and high volume. Bravo to Dr. Jameson!

Dr. Jameson assumed the position of Medical Director of Otolaryngology – Head & Neck Surgery Services at Avera McKennan Hospital & University Health Center in Sioux Falls, South Dakota. Avera Health network is a regional healthcare system based in Sioux Falls that serves South Dakota and surrounding areas of Minnesota, Iowa, Nebraska and North Dakota. He is charged with developing a comprehensive service line including all the subspecialty areas. Avera's network includes 6 integrated cancer centers and a very active multisite clinical trial program, so Dr. Jameson will most certainly stay on the front line of quality and innovation in head and neck oncology. This opportunity to CREATE has drawn Dr. Jameson from us but we are thrilled at the opportunity for him as well as the many patients he will be touching in that large health system. Best of luck, Dr. Jameson!

Stephen S. Park

DEPARTMENT CHAIR

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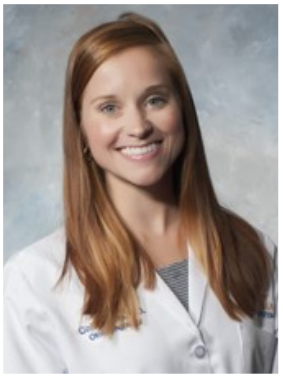
RESIDENT LIFE

MEET THE CHIEFS

Delaney Carpenter, MD

Ian Churnin, MD



Caitlin Iorio, MD

How do you feel your residency experience helped you prepare for the future?

Dr. Carpenter: I feel very well prepared to approach the breadth of otolaryngologic complaints. I feel that my training was exceptionally well-rounded with plenty of exposure to all of the ENT subspecialties, which gives me confidence as I venture out of my own!

Dr. Churnin: Residency is a humbling experience where you truly go from 0 to 100 with times of struggle, self doubt and being overwhelmed to becoming a confident and competent doctor and surgeon. You get to cherry pick the best aspects of each of your mentors and hone your craft to become the type of doctor to aspire to be when you leave.

Dr. Iorio: I truly feel as though I got the best surgical training there is to offer. I am excited to go into fellowship to further build on the excellent foundation I've built here. I feel competent as a surgeon and am very excited to take care of my own patients!

What is a major highlight of your residency?

Dr. Carpenter: The sinus course in Pittsburgh was very academically rewarding along with the opportunity to network. UVA is a very close knit group that empowers one another to offer help to attendings without being prompted. Our program offers juniors a ton of operative experience, especially for new surgeons.

Dr. Churnin: The highlight of the last five years had to be the addition of my firstborn, Milo. Coming home to my wife and him everyday kept me going. One of the most memorable professional highlights was seeing a former pan-facial ballistic trauma patient, whom Dr. Oyer and myself worked on for countless hours over many nights, come walking back into clinic months later with a new lease on life and thankful for our efforts.

Dr. Iorio: During one of my last days as Head & Neck chief, I was in a very complicated case the night of my celebratory service send-off party. Unfortunately, the case took longer than expected and due to a snow storm, I missed my party. However, in the hour leading up to the party, both other H&N Attendings came into our OR (even those from clinic) to check on us and actually acted as cheerleaders! That moment in time was the best representation of my time in residency, a family.

What are your plans following residency?

Dr. Carpenter: General ENT at UVA! I am so excited to join Dr. Mason and Dr. Landes.

Dr. Churnin: First and foremost, my wife and I are expecting our second child, a baby girl, who is due within days of my completion date. I am also excited to say that I have secured my dream job as I will be joining Raleigh Capitol ENT in NC come August. While I'm looking forward to practicing General Otolaryngology and dabbling in each sub specialty, I intend on developing a niche within Laryngology for the practice.

Dr. Iorio: I'm going into Facial Plastics Fellowship in Salt Lake City, Utah with Dr. P Daniel Ward. I am so excited to further my techniques and grow as a surgeon. I look forward to discovering where I'll be after fellowship

Favorites

Hike

Dr. Carpenter: Sugar Hollow to Blue Hole

Dr. Churnin: Anything along Skyline Drive

Dr. Iorio: Crabtree Falls

Fitz-Hugh Project

Dr. Carpenter: Laryngeal Fibroblast project with Dr. Daniero

Dr. Churnin: Novel In-Vivo Leporine (AKA Rabbit) Model for Glottic Insufficiency

Dr. Iorio: "Bell's Palsy: Seeking the Answers in Social Media"

Bodo's Order

Dr. Carpenter: Sausage, egg and cheese on everything

Dr. Churnin: Everything Bagel with Cream Cheese, Tomato and Lox

Dr. Iorio: Sausage, egg, and cheese on everything bagel with muenster and mustard

If you could take one thing with you from Charlottesville what would it be?

Dr. Carpenter: I can't choose ... but luckily I don't have to - we're not leaving! 🧡

Dr. Churnin: The Mountain Skyline! I will miss it in Raleigh.

Dr. Iorio: Floating the Rivanna

CONTINUED ON PAGE 16

ALUMNI NEWS

William Dougherty, 2018

Dr. Dougherty, Assistant Professor of FPS at EVMS in Norfolk, got engaged to Caroline Stocks last year while vacationing in Hawaii. The couple met in Norfolk where she is an ICU nurse and plan to tie the knot this September in Rome, Italy. Their handsome pup, Poe, couldn't be more excited! **CONGRATULATIONS Will and Caroline!!!**

Derek Robinson, 2014

After 7 yrs with Dr. Gates at Meadowcrest ENT, Dr. Robinson will be joining Dr. Michael Alexiou at Alexiou Hearing and Sinus Center in Harrisonburg, VA. as Dr. Gates approaches retirement.

Margeaux Corby, 2020

On 1/12/22 at 11:42AM Dr. Margeaux, General ENT at Wilmington Ear Nose and Throat, and her husband, Nestor, welcomed their first child, Freya Camellia Walker at 6lb. 12oz., and 19 inches. Freya is very inquisitive and has hair for days. She enjoys milk, crying at 2 am and walks in the park.

CONGRATULATIONS Margeaux and Nestor!

Bradley Kesser, 1998
Eugenia Gray, 1998

Class of 1998 co-chiefs, Dr. Bradley Kesser, UVA OtoHNS Vice Chair and Professor of Otology/Neurotology and Dr. Geni Gray, General Otolaryngologist at Union Hospital in Elkton, MD reunite at the annual American Academy of Otolaryngology meeting in Los Angeles last fall.

Heather Koehn, 2020

Dr. Koehn, Assistant Professor of Pediatric Otolaryngology at Augusta University's Children's Hospital, has been asked by the GA chapter of the AAP to write about CMV screening and hearing loss (See publication link below). You can also catch her on the local news this April for a World Voice Day interview about pediatric voice/speech. Follow us social media to see more.

https://www.gaaap.org/wp-content/uploads/2022/02/Newsletter-Winter-22-TGP.pdf

Alumni Update

We want to know what's going on in your life! Did you start a new appointment, retire, move to a new town, welcome a child or grandchild, send one off to college or attend their wedding.? All news is welcome great or small. Share your latest accomplishments and milestones at the link below to be featured in the next issue of What You Oto Know.

https://med.virginia.edu/otolaryngology/education/alumni/

MEET THE CHIEFS CONT.

What motivated you towards this specialty?

Dr. Carpenter: I love the variety that otolaryngology offers in terms of surgical technique.

Dr. Churnin: In medical school I was initially drawn to the hands on procedures and operating. After an exposure to General Plastics and being drawn the the Head and Neck Plastics/Reconstructive Surgery in particular, I was then introduced to the larger field of Otolaryngology. It was the only field where I could envision myself enjoying every single sub-specialty. Fortuitously, this initial intuition stuck throughout my training and I now embark on doing just that!

Dr. Iorio: I've wanted to be an ENT since I was 16 years old. With my moms' advice, I shadowed an General Otolaryngologist in high-school. I immediately fell in love with the variable techniques and range of patients. My love of the specialty has only grown with time.

UPCOMING EVENTS

2022 Fitz-Hugh Symposium & Alumni Reunion

The 46th annual Fitz-Hugh Symposium alumni reunion will be held **June 23-25, 2022** at Boar's Head Resort. One of the longest continuous Otolaryngology meetings in the country, every four years the gathering is dedicated to honor and highlight our alumni. Our last reunion attracted participants from around the world to gather, learn and socialize together. Scientific sessions Friday and Saturday will be balanced with social activities and our annual dinner. Boar's Head Resort serves as an amazing venue for our gathering. Come celebrate your UVA roots as we look not only at the past, but also the future of our specialty. **Registration is open now**, For more info visit our website https://med.virginia.edu/otolaryngology/events/2022-fitz-hugh-symposium/

Head & Neck Cancer Screening

April is Head and Neck cancer awareness month and in another post-pandemic revival our head and neck division looks forward to resuming its work to bring free head and neck cancer screenings to the community distributing educational materials on the major risk factors of head and neck cancer.

World Voice Day

April 16th is World Voice Day and for the first time in 3 years we will gather for our annual WVD celebration and concert on at Champion Brewing Company in Charlottesville on **Friday, April 22, 2022 from 7:00PM-10:00PM.** Headlining this year's event will be folk-pop singer-songwriter and CVille native and Wahoo, Genna Matthews.

2022 Jahrsdoerfer Visiting Professor

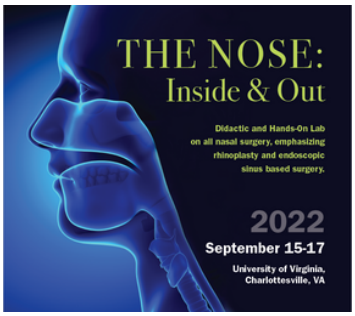
We are so excited to announce our first in-person Jahrsdoerfer Visiting Professor since 2019! On **May 12, 2022** we will host Dr. Barry Hirsch, Director of Otology/Neurotology at the University of Pittsburgh Medical Center. The day will be marked by morning and evening lectures from Dr. Hirsch, resident case presentations and the all-time favorite resident temporal bone drilling competition, judged by our very own Dr. Hashisaki.

Philanthropy

A gift to the University of Virginia Department of Otolaryngology- Head and Neck Surgery Resident Education Fund exclusively supports resident education at different levels including books, conferences, etc.

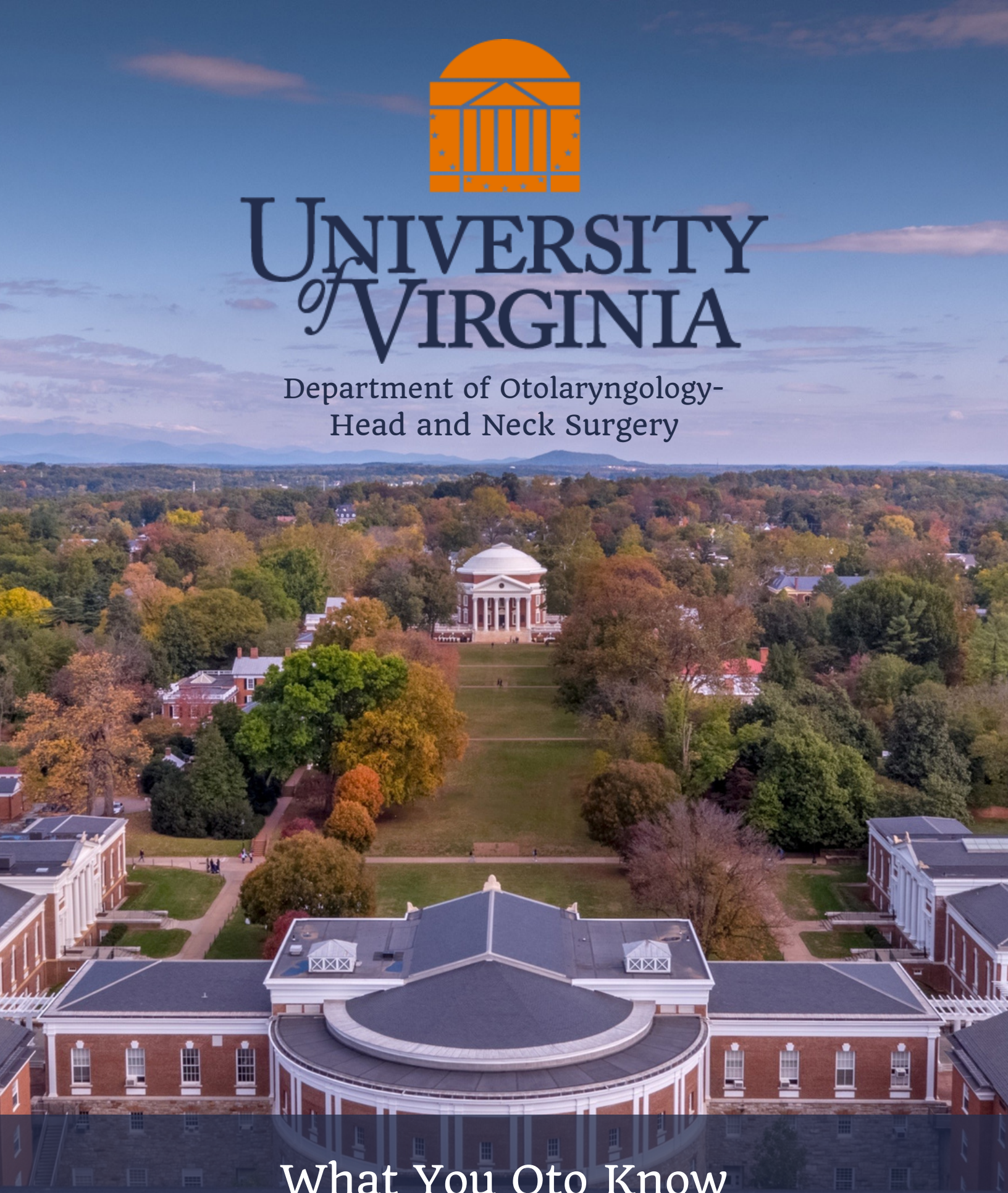
Please consider supporting the next generation of Otolaryngologists. If you would like to make a philanthropic investment in UVA Oto-HNS visit our website.

https://www.uvamedalum.org/giving/department-of-otolaryngology/



The Nose Course: Inside & Out

The 2022 Charles W. Gross Symposium on THE NOSE: Inside & Out is a multi-day comprehensive course on sinus surgery and rhinoplasty that will be held on **September 15-17, 2022** in Pinn Hall Conference Center at the University of Virginia. Lectures on Thursday and Friday will give way to a full day fresh cadaver hands-on lab on Saturday. Registration opening soon! Learn more on our website.
https://med.virginia.edu/otolaryngology/events/nose-course/



UNIVERSITY of VIRGINIA

Department of Otolaryngology-
Head and Neck Surgery

What You Oto Know

Spring VOL. 3, NO. 1