OTORHINOLARYNGOLOGY/
FACIAL PLASTIC SURGERY

RESIDENT MANUAL
DES PERES HOSPITAL
ST. LOUIS, MO 63122
Paul E. Burk, D.O., FOCOO
Program Director
Initial Manual date: 1991
Revised yearly
2015-16 Edition
Preface

Mission Statement

The mission of The Otolaryngology/Oro-Facial Plastic Surgery residency program at Des Peres Hospital is to educate and provide residents with the opportunities to become competent, proficient and professional Osteopathic Otolaryngologists/Oro-facial plastic surgeons. The department of Otolaryngology/Oro-facial Plastic Surgery is committed to following the basic standards as stated by the American Osteopathic Association along with the pursuit of new knowledge, competence, and improvement in each resident of the program.
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Books suggested to purchase that are not on list:
   Otologic Surgery by Brackmann and Shelton
   Surgery of the Ear by Glasscock and Shambaugh; there are multiple editions
   Pathology of the Ear by Schuknecht
   Tympanoplasty and Stapedectomy by Fisch

AOA Basic Standards for Otolaryngology/Oro-facial Plastic Surgery
AOA Basic Standards for Otolaryngic Allergy Fellowship Training
Educational Goals:
The overall educational goals of the Department of Otolaryngology/Oro-Facial Plastic Surgery Residency are:

1. To provide a strong background in the basic and clinical sciences related to Otolaryngology/Oro-Facial Plastic Surgery
2. To assist in the development of clinical and surgical expertise
3. To provide the opportunity to learn and practice research skills

All residents participate in a series of didactic lectures, clinical conferences, journal reading assignments, and independent reading which is directed primarily toward achieving the first goal. The effectiveness of this program is monitored by resident evaluation of the program, results of Home Study Course testing, results of the Annual Otolaryngology Examination, and success with the American Board of Otolaryngology certification process.

Common to all years will be the goals of the seven core competencies listed below:

Osteopathic philosophy and osteopathic manipulative medicine:
- Demonstrate and apply knowledge of accepted standards in OMT appropriate to Otolaryngology/Oro-facial Plastic Surgery
- Integrate osteopathic concepts and OMT into the medical care provided to patients as appropriate
- Demonstrate the treatment of people rather than symptoms
- Understand and integrate osteopathic principles and philosophy into all clinical and inpatient care activities

Interpersonal and Communication skills:
- Understand the importance of good communication, and its impact on patient care.
- Develop excellent communication skills with patients, peers, staff, and attendings.
- Learn how to interact with other health care professionals in a courteous manner.

Professionalism:
- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients’ ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:
- Learn how to work with an interdisciplinary team in the pre- and post-
operative care of the surgical patient.

- Become adept at interacting with social work for the post-hospital care of our patients.
- Learn how to approach patient care problems from a systems-based approach rather than the “band-aid” approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

**Practice-based learning:**

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

**Medical Knowledge:**

- Residents will demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral science, as well as the application of this knowledge to patient care.

**Patient Care:**

- Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

**Graduated Levels of responsibility:**

**OGME I** – Individuals in the OGME I year are closely supervised by more senior level residents and/or faculty. Examples of tasks that are expected of OGME I physicians include: perform a history and physical, start intravenous lines, draw blood, order medication and diagnostic tests, collect and analyze test results and communicate those to the other members of the team and faculty, obtain informed consent, place urinary catheters and nasogastric tubes, assist in the operating room performing tracheotomies and skin grafts and closure of wounds and perform other invasive procedures under the supervision of the faculty or senior residents at the discretion of the responsible faculty member. The resident is expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus for care. The first year resident must develop and implement a plan for study, reading and research of selected topics that promotes personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients. The resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the attending. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost effective care. Communication is emphasized this year including the ability to interact between health care services and exhibiting knowledge of systems-based practice.

Indirect supervision is adequate for the following patient care situations:

1. Initial evaluation and management of inpatients.
2. Preoperative & postoperative evaluation and management.
3. Patient transfers between floors and/or hospitals.
4. Discharging patients from the hospital.
5. Interpretation of lab results.
6. Procedures such as placement of IV’s, nasogastric tubes, Foley catheters, and arterial punctures.

Direct supervision is required for the following patient care situations, until competency can be demonstrated and documented:
1. Initial evaluation and management of patients with urgent or emergent conditions.
2. Evaluation and management of postoperative complications.
4. Management of patients in cardiac arrest. ACLS certification should be obtained.
5. Procedures such as:
   a. Advanced vascular access
   b. Closure of surgical incisions and/or lacerations
   c. Excision of superficial skin lesions
   d. Tubethoracotomy
   e. Paracentesis
   f. Joint aspiration
   g. Airway management, including orotracheal intubation and tracheostomy
   h. Tracheotomy tube exchanges
   i. Nasal Packing for epistaxis
   j. Drainage of peritonsillar abscess

Competency in each of the above listed skills will require being “signed off” by a more senior level resident and/or attending. Upon the notification of competency, the information can be submitted to either the Program Director or his/her designee for proper documentation in New Innovations.

OGME II – Individuals in the second post graduate year are expected to perform independently the duties learned in the first year and may supervise the routine activities of the first year residents. The OGME II may perform some procedures without direct (on-site) supervision such as facial laceration repair, debridement of wounds, endoscopy and foreign body removal from the nasal passageway and ear. Residents at this level can perform procedures and endoscopy under the direct supervision of faculty or senior level residents. The OGME II should be able to demonstrate continued sophistication in the acquisition of knowledge and skills in Otolaryngology and further ability to function independently in evaluating patient problems and developing a plan for patient care. The resident at the second year level may respond to consults and learn the elements of an appropriate response to consultation in conjunction with the faculty member. The resident should take a leadership role in teaching the OGME I and medical students the practical aspects of patient care and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The resident should be adept at the interpersonal skills needed to handle difficult situations. The OGME II should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other
members of the health care team.

**OGME III** – In the third year, the resident should be capable of managing patients with virtually any routine or complicated condition and of supervising the OGME I and OGME II in their daily activities. The resident is responsible for coordinating the care of multiple patients on the team assigned. Individuals in the third postgraduate year may perform all routine diagnostic and therapeutic procedures including endoscopy without direct (on-site) supervision. The OGME III can perform progressively more complex procedures under the direct (on-site) supervision of the faculty. It is expected that the third year resident be adept in the use of the literature and routinely demonstrate the ability to research selected topics and present these to the team. At the completion of the third year, the resident should be ready to assume senior level responsibility in those specialties requiring three years of training.

**OGME IV** – Individuals in the fourth post graduate year assume an increased level of responsibility as the chief or senior resident on selected services and can perform the full range of complex procedures expected of Otolaryngology under the supervision of the faculty. The fourth year is one of senior leadership and the resident should be able to assume responsibility for organizing the service and supervising junior residents and students. The resident should have mastery of the information contained in standard texts and be facile in using the literature to solve specific problems. The resident will be responsible for presentations at conferences and for teaching junior residents and students on a routine basis. The OGME IV should begin to have an understanding of the role of the practitioner in an integrated health care delivery system and to be aware of the issues in health care management facing patients and physicians.

**OGME V** – The fifth year resident, under the supervision of the faculty, takes responsibility for the management of the major surgical teaching services. The OGME V can perform most complex and high risk procedures expected of a physician with the approval of the attending physician. During the final year of training the resident should have the opportunity to demonstrate the mature ethical, judgmental and clinical skills needed for independent practice. At the Program Director’s discretion, the OGME V may be asked to present a formal presentation at scientific assemblies, or participate as a member of a discussion panel as well as assuming a leadership role in teaching on the service. The mores and values of the profession should be highly developed, including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of medicine.

**ALL YEARS – ALL RESIDENTS:**
Grand Rounds, Journal Clubs, Morning Report weekly. Attendance must be documented on the sign in sheet
WHAT TO KNOW AND WHAT TO DO AS A FIRST YEAR RESIDENT

First Year Resident Checklist (OGME-2) – To be done by the 10th month of Intern Year (OGME-1)

• During resident orientation (beginning of OGME-1 year), be sure to get the manual from Medical Education which describes policies, etc. of Des Peres Hospital in conjunction with the resident manual, syllabus, and curriculum of the Otolaryngology/Oro-facial Plastic Surgery Program.

• Confirm with Medical Education that all pertinent information has been sent to med staff offices at DePaul, St. Joseph Health Care and Barnes St. Peters.

• Familiarize the log database sent to you with CPT codes and formatted templates present at hospitals in which you rotate and the attending’s offices

• Become a member of:

• Confirm Membership with Medical Education for AOA, AOCOO-HNS, MAOPS, and SLAOPS

• Sign up for Home Study Course with membership ID from the Academy www.entlink.net/education/programs/hsc.cfm (Home study required for 2 years out of your residency) It is suggested to begin the course in R2. There are 8 units—4 each year. You are required to submit your testing answers prior to the first deadline with a copy to the Program Director. If you submit your answers late, they may be scored; however, the Program Director will not give you credit for that section

• In Service exam required every year (2-5)

• Obtain Permanent License by the end of this year

Medical License # ____________________________

AOA ID # ________________________________

MAOPS ID # ______________________________

AOOCOHNNS # __________________________

AAO-HNS # ______________________________

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AOCOO-HNS Resident Submissions by Year

- Year End Reports due by July 30th
- First Year (specialty track internship)-Forms available on AOCOO-HNS website
  - Resident’s Annual Report (surgery logs)
  - Accumulated Tracking Log Form
  - General Surgery Director’s Annual Report and Program Requirements checklist

- Second Year
  - Resident’s Annual Report, Residency Checklist
  - Program Director’s Annual Report
  - Professional Paper (see Appendix IV of the Basic Standards)
  - Home Study Course
  - Accumulated Tracking Log Form

- Third Year
  - Resident’s Annual Report, Residency Checklist
  - Program Director’s Annual Report
  - Professional Paper (see Appendix IV of the Basic Standards)
  - Home Study Course
  - Accumulated Tracking Log Form

- Fourth Year
  - Resident’s Annual Report, Residency Checklist
  - Program Director’s Annual Report
  - Professional Paper (see Appendix IV of the Basic Standards)
  - Home Study Course
  - Accumulated Tracking Log Form

- Fifth Year
  - Resident’s Annual Report, Residency Checklist
  - Program Director’s Annual Report
  - Accumulated Tracking Log Form
Otolaryngology Resident Vacation and Holiday Policy

- Residents are allowed 3 weeks of vacation per academic year
- Three major and four minor holidays

**Major:**
Christmas
New Year
Thanksgiving

**Minor:**
Memorial Day
Labor Day
Easter
Fourth of July

- The Chief Resident will be assigned 4th of July holiday call. Each of the other residents will work one major and one minor holiday. The OGME IV resident will select their holiday call first, followed by others.

- Vacation taken between Christmas and New Year will be allowed only if the Otolaryngology service is adequately covered. If 3 residents are needed and 2 residents request vacation during this same time-the following policy:
  - Which ever resident has not taken previous vacation time during this period between Christmas and New Years will be granted the vacation time.
  - If both residents have taken previous vacation time during this period then it will alternate. You may not take vacation during this period 2 years in a row.
  - Any exceptions are only with the Program Director’s approval.

**Council of Resident Representatives**

- This is a council that is to have one spokesperson, who is a resident from both divisions of the college (1 OPTH, 1 ENT)
- The council rep is at all of the college board meetings and is the resident’s representative. The council rep’s job is to take your problems to the board and decimate information to the residents.

- Our program is to have a resident whom the council representative can contact and vice versa.

- The OGME 4 resident is the contact person from our program. The OGME 4 resident is responsible for finding out the council representative for ENT and contacting them to notify the representative of how to get a hold of our contact person (phone, email, etc). Notify the Program Director as soon as you have done this.

**Resident Paper Deadlines**

- Subject: October 1\textsuperscript{st}
- Outline: January 1\textsuperscript{st}
- Rough Draft: March 1\textsuperscript{st}
- Final Paper: May 1\textsuperscript{st}

**AOCCOHNS Course Requirements: (See Basic Standards)**

- Allergy
- Facial Plastic Surgery
- Head and Neck Surgery
- Laser Surgery
- Temporal Bone Surgery
- Basic Science Course

Head and Neck Anatomy and Basic Science course required during first or second year:

Iowa City, Iowa [www.iowabasicscience.org](http://www.iowabasicscience.org)
Indianapolis, Indiana [www.iupui.edu/~cmeweb/05127/Histo04Reg.htm](http://www.iupui.edu/~cmeweb/05127/Histo04Reg.htm)

SLU provides many CME courses that meet these requirements: [http://pa.slu.edu/index.phtml?page=CMEWorkshops](http://pa.slu.edu/index.phtml?page=CMEWorkshops)

Iowa also has Head and Neck Surgery/Laser Course
Out-Rotations

- AOCOOHNS Regulations:
  - No more than 6 months at an outside facility consecutively
  - No more than 16 months on out rotations total (1/3)
  - No out rotations during last 6 months of final year

Recommendations for Out-Rotations

OGME 2: Pediatrics (3 months total – 1, 2 or 3 months this year-the remainder next year) Facial Plastics (2-3 months –depending on the numbers you achieve)
OGME 3: Pediatrics (whatever hasn’t been done prior)
  - Facial Plastics (1 month, if needed)
  - SLU Head and Neck (3 months)
OGME 4 and PGY5: Otology (3 months)/Neuro-Otology
  - Head and Neck Oncology (2-3 months) This may be done in OGME 3, if it can be worked out
  - See attached Appendix: Otology notes from Dr. Van Ness (when you go on this rotation, these are his suggestions)

OGME1 – Internship Rotations

Please notify the Program Director as soon as possible of your rotations to be sure the rotations are appropriate for ENT.

Medical Records

- Medical Records must be done weekly. There should never be a time when the Program Director is notified that a resident is delinquent. EMR-during clinics residents will learn to manage this system
- Operative Reports should be done as close to the time of the surgery as possible. As an example, doing a report 5 days after surgery – a resident could leave out that arch bars were used before plating.
**Educational Protocol**
In order to provide the best educational training for residents, the below rules are to be followed. Residents are to abide by the following rules, by order of importance of their duties, in determining where they need to be. **The in-house senior resident is responsible for scheduling residents according to this protocol.**

1. **Grand rounds** and Lectures at SLU 7:30-8:30am (residents would not be available on Wed till 9 am because they must go to the lecture)

2. **Surgeries** Any major cases take precedence over clinic. (if there is a conflict with not enough residents for all the cases, the residents are to select the best cases and let the other attending(s) know that he will not have coverage) **Residents are to do any surgeries available before any clinics.** Residents should apply common sense in making decisions….3 residents shouldn’t show up for a set of tubes and not have clinic covered. On the other hand, a frontal sinus or radical neck (major cases) should have all residents as opposed to any resident doing clinic.

3. **Post Op Clinic** should be covered by a resident. It may need to be moved/rescheduled to be sure that surgeries are covered first, then post op clinic. It is important that post op clinic remain covered, so it would need to be moved/rescheduled to accommodate this. **The in-house senior resident should monitor this and move/reschedule post op clinics if conflicts occur.**

4. **Medicaid clinic** Clinic is to be covered for each doctor on an equal basis, if there is ever a conflict where there are not enough residents to cover clinics-- whomever has the most Medicaid clinic patients is where the resident is to go. At no time, should two residents participate in one clinic leaving the other clinic without a resident.

5. **Temporal Bone Lab** (done only when other things are completed, the dilemma is that it maybe available only when clinic is running, **the resident should alert the attending that there will be no resident that day**)

6. **Educational requirements** At this time, you have 5 educational opportunities per week that are expected of you. (this does not apply to the R-1 level...that person can attend what they can make)
To recap what these are:

1. Monday afternoon lecture series **(also includes temporal bone lab*)
2. Monday evening allergy lecture**
3. Wednesday morning SLU lectures **
4. Wednesday afternoon red book studies (board review)**
5. Friday morning book club**

* The only educational opportunity that you cannot make up would be temporal bone drilling if you are on an out rotation--ex: Indianapolis,Otology
** These are to be done no matter where you are-ex: If you are in Indianapolis on a Friday book club--you are still responsible for those chapters. Further—ex: If you missed the Wednesday allergy lecture about asthma-- you should still have read on the subject. If you miss the afternoon red book studies--you need to cover the same subject.

Any required or suggested meetings are to be considered after the five educational requirements above.

**Weekly Book Club**  (Do not get lax in doing this)

1. Book club dates and times are to be on the master resident schedule. There should be at least 4 weekly book club meetings a month.
2. A sign in sheet is to be kept and a copy of said sheet is to be given to the Administrative DME and myself monthly.
3. Is it the responsibility of the senior resident to schedule book club meetings and make sure that the sign in sheets are handled appropriately. If the senior resident is out for any reason, this responsibility will fall to the next most senior resident to complete.

**Reading**

1. A minimum of 1 book per year should be read by each resident
   A: OGME 1 – general ENT/Ballenger
   B: OGME 2 – Cummings
   C: OGME 3 – Bailey
   D: OGME 4 – Otology/head and neck
2. I want to talk to each one of you individually about what books you have read so that we can make sure this fits with what has already been done.
3. Of course, you will supplement with other reading depending on what rotation you are doing.

   *The above is separate from weekly book club reading*
In Service Review Form

Based on grading of your year, if your in-service scores are one (1) or two (2) in the cumulative or composite scale, this would mean you scored in the lower 3-5% in the test. The following will be done in order to help correct this problem:

1. Daily reading of at least an hour from a book that is mutually agreed upon by the resident and program director—until the book is completed. If the book is completed—we will pick a new book. This is outside of your normal reading. Ex: preparing for a case.
2. This is to be completed 7 days a week—no exceptions (vacations, etc.)
3. A weekly summary from the book read, chapter and page numbers to be given to Program Director.
   a. Ex: KJLee, Chapter 1, pages 1-38 week 1
4. Five questions from the week’s of reading
   a. Ex: Week 1 – KJLee, Chapter, Pages, 1-38
      i. Question 1 in multiple choice answer
      ii. Question 2 in multiple choice answer
      iii. Question 3 in multiple choice answer
      iv. Question 4 in multiple choice answer
      v. Question 5 in multiple choice answer
5. In a rolling one-year time frame—52 summary/logs with questions are to be completed and numbered 1-52.
6. The summary with questions is due once a week for the previous week. Ex: week 1—June 16-22. The summary is due to the director on Monday, June 23. There should be no exceptions to this without prior authorization.
7. The summaries may be placed in the directors’ box on Mondays or e-mailed. Whatever format chosen should be consistent.
8. If ones in-service scores are low again for a second year—the process will be repeated.
9. This is a condition of your continuation of residency within our program.

The Program Director has gone over my in-service review form and I am aware of my requirements as listed above.

Print: ______________________________________
Resident Name

Sign: ______________________________________ Date: __________
Resident Signature

Sign: ______________________________________ Date: __________
Paul E. Burk, D.O., F.O.C.O.O.
POLICIES

In addition to the policies below, you are to comply with all applicable policies and procedures of Des Peres Hospital and any other hospitals in which you are doing an out-rotation or relevant clinical facilities. During orientation, you will receive a manual from the Medical Education Office that lists policies that are not covered below.

A. Technical Qualifications for residents

Technical standards for Otolaryngology have been established to allow the resident candidate to determine their ability to perform the required duties in compliance with the Americans with Disabilities Act.

An otolaryngology resident must have abilities and skills in five categories: observation, communication, motor, intellectual, behavioral and social. However, it is recognized that degrees of ability vary widely between individuals.

1. Observation: A candidate must be able to observe a patient accurately at a distance and close at hand. In detail, observation necessitates the functional use of the sense of vision and other sensory modalities. Full color vision and binocular vision are necessary for the successful performance of otolaryngology surgery.

2. Communications: A candidate must be able to communicate effectively and sensitively with patients. The focus of this communication is to elicit information, describe changes in mood, activity, and posture, and perceive nonverbal communications. Communication includes not only speech, but reading and writing. The candidate must be able to communicate effectively and efficiently in oral and written formats with all members of the health care team.

3. Motor: Candidates must have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. A candidate must be able to execute motor movements reasonably required to provide general care and emergency treatments to patients. Such actions require coordination of both gross and fine muscular movements, equilibrium, and functional use of the senses of the touch and vision.

4. Intellectual-Conceptual, Integrative and Quantitative Abilities: These abilities include measurement, calculation, reasoning, analysis, and synthesis of complex information.

5. Behavioral and Social Attributes: A candidate must possess the emotional health required for full utilization of his or her intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients. Candidates must be able to tolerate physically taxing workloads and to function effectively under stress. They must be able to adapt to changing environments, to display flexibility, and learn to function in the face of
uncertainties inherent in the clinical problems of many patients. Compassion, integrity, interpersonal skills, interest and motivation are all personal qualities that are assessed during the selection and education process.

B. Social Networking Policy – As medical professionals, resident physicians are expected to conduct themselves with the utmost in professionalism, whether in personal interactions or when online. Residents should refrain from engaging in any unprofessional behavior, inappropriate language, posting of offensive photos or materials when engaged in online activities. Failure to maintain the minimum standards of professionalism may result in disciplinary action.

C. Sick Leave
   a. If, for any reason you need to take sick leave, call or speak with the Residency Program Director

D. Vendor/Industry Interactions
   b. Residents may not accept gifts from vendors/industry, regardless of value
   c. Residents are not permitted to accept books, instruments and other teaching aids from industry representatives or vendors.
   d. On-site access by industry representatives or vendors is restricted to non-patient care and public areas only. Industry representatives and vendors are permitted access to patient care areas and non-public areas only when their presence is necessary for educational purposes and then only by appointment and, when appropriate, with the prior consent of the patient. Such on-site access by industry representatives and vendors must be under the constant supervision of a COM faculty member.

E. Residents must abide by the rules and policies as stated in the AOA Basic Standards for Otolaryngology/Oro-facial Plastic Surgery residents. See section 7-Resident Requirements.

F. Meetings - Section 7.7 states residents must attend 70% of all meetings as directed by the Program Director. Residents are to attend various meetings throughout the five year academic training program. These may include national meetings such as the ACA, educational meetings such as the Basic Allergy, local political meetings such as MAOPS and SLAOPS, Journal clubs, book clubs, reading club, OMT, Board Review, and hospital committee meetings. The Program Director will designate meetings which are mandatory and those which are suggested.

Mandatory meetings require 100% attendance; suggested meetings require 70% attendance. Residents should follow the order of educational protocol in attending any suggested meetings. If unable to attend the meeting due to other educational criteria, review of the minutes or subject of the meeting will suffice. The Program Director will notify the resident in writing if the above protocol requirements for meetings are not being met.

Educational Protocol:
1. Didactics (lectures)
2. Board Reviews
3. Surgery
4. Meetings of various types
5. Clinic

Residents may participate in educational and CME activities that conform to AOA/ACGME requirements.
# Des Peres Hospital

**ENT Schedule**
*(Subject to change)*

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APPENDIX I: NOTES FROM DR. VAN NESS

Otology

Rounds
- Mastoid dressings
  - Gantz – change every day.
  - Hansen - change every other day.
  - Dressing supplies include: adaptec, bacitracin, kerlix lite rolls, kerlix fluffs (10), scissors, +/- elastoplast. Have the mastoid dressings removed prior to rounds.
- Check FN function, nystagmus, and incision site daily.

Clinic
- Med students are NOT allowed to clean ears
- In Gantz clinic, med students should staff with resident first so that resident can examine and fill out the physical exam portion.
- Basic ear H&P: otalgia, otorrhea, hearing loss, vertigo, tinnitus, prior ear surgeries, family hx
- General Pre-op:
  - ALL ear cases need audio w/in 3 months of surgery:
    - All translabs, mega skullbase, and Marlan’s MCFs should include abdominal fat graft on consent; Ask if need possible placement of lumbar drain in consent. Also risk of stroke, embolism, death, facial paralysis, taste dysfunction, inbalance, deafness, CSF leak, meningitis.
  - EAC dermatitis (itchy ears)
    - Gantz – Synalar 0.25% cream tid in 15g tube or 0.01% solution tid in 20ml bottle
    - Hansen – Valisone 0.1% ointment qday to bid

General considerations
- All big otology cases should get full lab panel including coags and medicine clearance if deemed necessary
- Document facial nerve function, Weber, Rinne, audiogram within 6 months
- General otology/neurotology antibiotics (unless specified below)
  - Perioperative
    - Adults and children- Cefazolin IV and Decadron before incision.
    - Penicillin allergic - Clindamycin IV and Decadron before incision.
  - Postoperative
    - All other otology procedures aside from CWR, CI and BAHA – No postop oral antibiotics – (this includes skull base procedures).
• Transcanal procedures - antibiotic drops (MH-fluoroquinolone, BG-cortisporin) BID until follow-up appointment with attending at one month.
• Bacitracin to endaural and postauricular incisions BID starting after dressing removal.

OR prep: Tape up pre-op audio. No paralysis. Position patient on bed closer to operative side, head on Reston, bump under head if necessary to keep from rolling, tube taped off opposite. Turn 180deg, strap and test roll.

Case specific pearls

Middle ear cases
• if done under local, use Phenergan, Demerol, and Versed IV for sedation.

Cochlear implants
• most patients will stay for 23 hr obs (usually in CRC). They may take their mastoid dressing off on POD #2. They should go home w/ Abx . Will return to AUDIOLOGY in 1 month for hook up, not our clinic.
• Keflex / clindamycin PO 1 week post-op

BAHA
• usually outpatient. Keflex/ clindamycin x 1 week post-op
• BAHA’s follow-up in one week in MH clinic for healing cap removal.

Stapedectomy/stapedotomy
• most patients will go home same day (Marlan) or stay for 23 hr obs (Gantz). For Gantz patients he wants them to lie flat for 6 hrs after surgery.
• Always do Weber test to ensure that they lateralize to operated ear. .
• Stapes and any cases with inner ear fistula get fluoroquinolone drops BID starting morning after surgery until follow-up appointment with attending at one month. Home care instructions: dry ear, nose blowing precautions, avoid flying. Should come immediately to the hospital if they are having vertigo or hearing loss! If so, needs to be seen immediately and checked with audiogram and nystagmus. No postop oral antibiotics.
• F/u in 1 month for ear cleaning, f/u 4 months for audiogram

Tymp-mastoid
• f/u 7 days for suture and packing removal, then use gtts until f/u at 1 month. RTC for bowl cleanings q6mo

Canal Wall Reconstruction Tympanomastoidectomy
• Gantz admits for 48 hours of IV antibiotics, D/C Penrose drain POD #2, and home on Levaquin. Marlan will usually D/C day of surgery, home on Levaquin.
• Adults - Zosyn and Cipro 750 bid IV before incision and for 48 hours postoperatively. Discharge on Cipro PO X 2 wk.
• Children - Zosyn IV before incision and for 48 hours postoperatively. Discharge on Augmentin PO X 2 wk.
• Penicillin allergic adults - Clindamycin and Cipro IV before incision and for 48 hours postoperatively. Discharge on Levaquin PO X 2 wk.
Penicillin allergic children - Clindamycin IV before incision and for 48 hours postoperatively. Discharge on Clindamycin PO X 2wk.
Antibiotic drops (MH-Ciprodex, BG-Cortisporin) used BID starting after packing/suture removal at one week in ROD clinic and continuing until follow-up visit with attending at one month.
Bacitracin to incision BID starting after dressing removed.

Endaural and Canal Wall Down procedures
- packing/suture removal in ROD clinic at one week then antibiotic drops (MH-fluoroquinolone, BG-cortisporin) BID until follow-up appointment with attending at one month

Acoustic Neuromas
- Make sure pt has preop ABR and we have preop films.
- Call SICU in AM to check they are expecting the patient.
- Advise anesthesia to run the patient dry and have in the room manitol 0.25-0.5 g/kg.
- Need NIMS; no paralysis for ANY ear case (all general cases use NIMS), and Foley
- MCF
  Gantz - also need to order 4-view Stenver skull film. Will use temporalis fascia Hansen – no Stenvers. Consent for abdominal fat graft. Use ResorbX plating system. Preop: 3 days of valcyclovir.
  Patients will stay in SICU overnight for NSG monitoring. Some may have LD placed which will be managed by NSG. On POD #1 rounds be sure to be prepared with transfer orders (can use admit acoustic neuroma 3JPW orders) in hand. We have an agreement that if the patients are stable we will have transfer orders prepared by rounds. Home on POD #3-5 if leak test is negative, ambulating well, taking PO, no sign of meningitis. Dressings for Gantz to stay on 5 days, Hansen to stay on 4 days. F/U in 7-10 days for suture removal unless their PMD will remove for them.

Skull base procedures
- need ophtho, NSG consults
- Consent for possible abdominal fat graft
- Periop abx - Vancomycin 1gm q 12, Flagyl 500mg q 6, Ceftax 2gm q 8 (from* Kraus*, Standardized regimen of abx in skull base surgery)
Appendix
II

DES PERES HOSPITAL, HOLDINGS, TEXTBOOKS

Otolaryngology/Facial Plastic Surgery textbooks
February, 2016


Krouse. Allergy and Immunology: an Otolaryngic approach. Lippincott, Williams and Wilkins, c2002.


Merchant. **Schuknecht’s Pathology of the ear.** People’s Medical Publishers, c2010.


Snow. **Ballenger’s otorhinolaryngology, head and neck surgery.** B. C. Decker, c2009.


Wormald. **Endoscopic sinus surgery: anatomy, three-dimensional reconstruction and surgical technique.** Thieme, c2013.

Wormald. **Endoscopic sinus surgery: anatomy, three-dimensional reconstruction and surgical technique.** Thieme, c2005.


Bailey. **Head and neck surgery – otolaryngology.** Lippincott, Williams & Wilkins, c2006.

King. **Allergy in ENT practice.** Thieme, c2005.

Baker. **Local flaps in facial reconstruction.** Mosby Elsevier, c2007. (cataloged with WE)

Lore. **An atlas of head and neck surgery.** Elsevier Saunders, c2005. (cataloged with WE)

**Board Review**

**Osler Otolaryngology Board Review,** audio CD’s

**Otolaryngology/Facial Plastic Surgery, Current Journal Subscriptions**

Annals of Otology, Rhinology and Laryngology
JAMA, Otolaryngology – Head and Neck Surgery
Otolaryngology Clinics of North America

**Otolaryngology/Facial Plastic Surgery E-Books, Available through the ATSU portal**
Ahuja. Practical Head and Neck Ultrasound. Cambridge University Press, 2000
Alpini. Whiplash Injuries Diagnosis and Treatment. Springer, 2014
Bailey. Head & Neck surgery-otolaryngology. Lippincott Williams & Wilkins, 2006
Becker. Ear, nose, and throat diseases with head and neck surgery. Thieme, 2009
Bull. Color atlas of ENT diagnosis. Thieme, 2010
Chokroverty. Sleep disorders medicine basic science, technical considerations, and clinical aspects. Saunders/Elsevier, 2009
Dhillon. Ear, nose, and throat and head and neck surgery an illustrated colour text. Elsevier, 2013
Dunnebier. Imaging for otolaryngologists. Thieme, 2011
Eiber. Middle Ear Mechanics in Research and Otology: Proceedings of the 4th International Symposium. 2006
Ekberg. Dysphagia Diagnosis and Treatment. Springer, 2012
Jahnke. *Middle Ear Surgery: Recent Advances and Future Directions*. Thieme, 2004
Langdon. Understanding Cosmetic Laser Surgery. (Understanding health and sickness series). University of Mississippi, 2004
Levine. Anesthesiology and Otolaryngology. Springer, 2013
Lucente. Essentials of otolaryngology. Lippincott Williams & Wilkins, 2004
Mankekar. Swallowing – Physiology, Disorders, Diagnosis and Therapy. Springer, 2015
Mankekar. Implantable Hearing Devices other than Cochlear Implants. Springer, 2014
Mansour. Tympanic Membrane Retraction Pocket Overview and Advances in Diagnosis and Management. Springer, 2015
Pagel. Primary Care Sleep Medicine A Practical Guide. Springer, 2014
Pankey. Contemporary Diagnosis and Management of Sinusitis. Charles W. Associates in Medical Marketing, 2004
Pensak. Controversies in Otolaryngology. Thieme, 2001
Pensak. Otolaryngology cases the University of Cincinnati clinical portfolio. Thieme, 2010
Pensak. Clinical Otology. Thieme, 2014
Schulze. Plastic Surgery Case Review. Thieme, 2014
Staecker. Otolaryngology, Basic Science and Clinical Review. Thieme, 2006
Valente. *Audiology Answers for Otolaryngologists.* Thieme, 2011
Wada. *Proceedings of the 3rd Symposium on Middle Ear Mechanics in Research and Otology,* 2003
Waltzman. *Cochlear implants.* Thieme, 2014

**Otolaryngology/Facial Plastic Surgery, E-Journals,** Available through the ATSU portal

Acta Chirurgiae Plasticae, 2011 to present
Acta Oto-Laryngologica, 1998 to present, Full text delay: 18 months
Advances in Cellular and Molecular Otolaryngology, 2013 to present
Aesthetic plastic surgery, 1997 to present
American Journal of Otolaryngology, 2007 to present
American Journal of Otology, 1979 to 2000
American Journal of Rhinology, 2003 to 2008
American Journal of Rhinology & Allergy: Official Journal of the American Rhinologic Society and the International Rhinologic Society, 2009 to present
Annals of Otology, Rhinology & Laryngology, 2002 to present
Annals of Plastic Surgery, 1978 to present
Archives of facial plastic surgery, 1999 to 2012
Archives of otolaryngology – head and neck surgery, 1998 to 2012
Archives of Plastic Surgery, 2012 to present
Arquivos Internacionais de Otorrinolaringologia, 1997 to present
Audiology and Neuro-otology, 2005 to 2011
Auris Nasus Larynx, 2008 to present
Bangladesh Journal of Otorhinolaryngology, 2008 to present
Bangladesh Journal of Plastic Surgery, 2010 to 2013
BMC Ear, Nose, and Throat Disorders, 2001 to present
Brazilian Journal of Otorhinolaryngology, 2005 to present
British Journal of Plastic Surgery, 1995 to 2005
Case Reports in Otolaryngology, 2011 to present
Cirugia Plastica Ibero-Latinoamericana, 2006 to present
Clinical and Experimental Otorhinolaryngology, 2008 to present
Clinical Medicine Insights: Ear, Nose and Throat, 2008 to present
Clinical otolaryngology, 2005 to present, Full text delay: 1 year
Clinical otolaryngology & Allied Sciences, 1998 to 2004
Clinical Otology Japan, 2974 to 1990
Clinics in Plastic Surgery, 2007 to present
Craniomaxillofacial Trauma and Reconstruction, 2008 to present
ENToday, 2006 to 2009
GMS Current Posters in Otorhinolaryngology: Head and Neck Surgery, 2009 to present
GMS Current Topics in Otorhinolaryngology, Head and Neck Surgery, 2004 to present
GMS German Plastic, Reconstructive and Aesthetic Surgery, Burn and Hand Surgery, 2011 to present
Current Opinion in Otolaryngology & Head & Neck Surgery, 1994 to present
Current Otorhinolaryngology Reports, 2013 to present
Ear, Nose & Throat Journal, 1994 to present
Eplasty, 2004 to present
Egyptian Journal of Ear, Nose, Throat and Allied Sciences, 2011 to present
European Annals of Otorhinolaryngology, Head and Neck Diseases, 2010 to present
European Archives of Oto-Rhino-Laryngology, 1997 to present
European Journal of Plastic Surgery, 1997 to present
Facial Plastic Surgery Clinics of North America, 2007 to present
Head and Neck, 2005 to present, Full text delay; 1 year
Head and Neck Oncology, 2009 to present
HNO, 1997 to present, Full text delay: 1 year
Indian Journal of Otolaryngology and Head & Neck Surgery, 2001 to present
Indian Journal of Otology, 2011 to present
Indian Journal of plastic surgery, 2001 to present
International Archives of Otorhinolaryngology, 2005 to present
International Journal of cosmetic surgery and aesthetic dermatology, 2000 to 2003
International Journal of Otolaryngology, 2009 to present
International Journal of Otolaryngology and Head & Neck Surgery, 2012 to present
International Journal of Pediatric Otorhinolaryngology, 2007 to present
Internet Journal of Otorhinolaryngology, 2000 to present
Internet Journal of Plastic Surgery, 2001 to present
Iranian Journal of Otorhinolaryngology, 2008 to present
ISRN Otolaryngology, 2011 to present
ISRN Plastic Surgery, 2013 to present
ISRN Surgery, 2011 to present
JAMA Facial Plastic Surgery, 2013 to present, Full text delay: 35 days
JAMA Otolaryngology – Head & Neck Surgery, 2013 to present, Full text delay: 35 days
Journal of the Association for Research in Otolaryngology: JARO, 2000 to present, Full text delay: 2 years
Journal of Hearing Science, 2011 to present
Journal of International Advanced Otology, 2009 to present
Journal of Laryngology & Otology, 2002 to present
Journal of Laryngology and Voice, 2011 to present
Journal of Japan Society of Immunology & Allegology in Otolaryngology, 2011 to present
Journal of Otolaryngology, 1997 to 2007
Journal of Otolaryngology – Head and Neck Surgery, 2013 to present
Journal of Plastic Reconstructive and Aesthetic Surgery, 2007 to present
Journal of Plastic Surgery and Hand Surgery, 2010 to present
Journal of Whiplash & Related Disorders, 6/06 to 12/06
Kulak-Burun-Bogaz ve Bas-Boyun Cerrahisi Dergisi = Turkish Journal of Ear, Nose, and Throat, 2011 to present
The Laryngoscope, 1997 to present
Microsurgery, 2012 to present, Full text delay: 1 year
Modern Plastic Surgery, 2011 to present
National Journal of Maxillofacial Surgery, 2010 to present
National Journal of Otorhinolaryngology and Head and Neck Surgery, 2005 to present
Online Journal of Otolaryngology, 2011 to present
The Open Otorhinolaryngology Journal, 2007 to present
Operative Techniques in Otolaryngology – Head and Neck Surgery, 2007 to present
Ophthalnic Plastic & Reconstructive Surgery, 1985 to present
Otolaryngologic Clinics of North America, 2007 to present
Otorinolaryngologie a Foniatrie, 2011 to present
Otorynolaryngologia, 2007 to present
Otolaryngology – Head and Neck Surgery, 1999 to present
Otolaryngology – Head and Neck Surgery (Elsevier), 1997 to 2010
Otology & neurotology, 2001 to present
Otology Japan, 1991 to 2014
Patient Management Perspectives in Otolaryngology, 2011 to present
Pediatric Otorhinolaryngology Japan, 1980 to present
Plastic & Reconstructive Surgery, 1946 to 1999
Plastic and Reconstructive Surgery, 1962 to present
Plastic Surgery, 2014 to present
Plastic Surgery: An International Journal, 2013 to present
Plastic Surgery International, 2010 to present
Plastic Surgery Practice, 2012 to present
Revista Brasileira de Cirurgia Plastica (Impresso), 2010 to present
Rhinology, 2008 to present
Rhinology. Supplement, 2010 to present
Seminars in Plastic Surgery, 2004 to present, Full text delay, 1 year
World Articles in Ear, Nose and Throat, 2012 to present