

AHNS 2013

ANNUAL MEETING

During the Combined Otolaryngology Spring Meetings



April 10 - 11, 2013

**JW Marriott Grande Lakes
Orlando, Florida**

FINAL PROGRAM

The Research and Education Foundation of The American Head & Neck Society

What is the Research and Education Foundation of the American Head and Neck Society?

The American Head and Neck Society (AHNS) is the single largest organization in North America for the advancement of research and education in head and neck oncology. Founded in 1998 as a merger between two smaller societies, the AHNS offers a community for professionals working with head and neck cancer. **The Research and Education Foundation of the American Head and Neck Society was developed as a means to promote the ideals and mission of the society.**

What does the Research and Education Foundation do?

The Foundation wants to support head and neck cancer research especially for young investigators who will make the discoveries needed to improve survival, decrease treatment morbidity and preserve speech and swallowing function. Young investigators often have difficulty competing for limited funds. **The Foundation wants to provide opportunities for basic, translational and clinical research grants in head and neck cancer and education.**

How can I be involved?

In order to provide these grants, the Foundation relies solely on the generosity of AHNS members, physicians and other individuals, and grateful patients. **Your support is invaluable.** There are many ways to give: Pledge commitments, Centurion Club, and more. We strongly encourage giving at the Centurion Club level, where you receive special recognition and privileges; however, all level of gifts are appreciated and welcome.

What grants does the Foundation support?

While our goal is to fund 100% of the grants offered through the AHNS, we currently have two unique award opportunities: The Chris O'Brien Traveling Scholar Award and the Duane Sewell Young Investigator Award. These are both offered in memory of talented and passionate physicians who were also members of the AHNS. To learn more about these awards, please visit our website, where you may also chose to make donations to these funds.



To make a donation, please visit

www.ahnsfoundation.info

**OR go to the AHNS
Registration Desk and
ask for a donation form.**



**American Head and Neck Society
2013 Annual Meeting**

**During the Combined Otolaryngology
Spring Meetings**

MEETING PROGRAM

**April 10-11, 2013
JW Marriott Grande Lakes
Orlando, Florida**

The American Head & Neck Society (AHNS)
11300 W. Olympic Blvd., Suite 600
Los Angeles, CA 90064
Phone: (310) 437-0559
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www.ahns.info

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AHNS 2013 ANNUAL MEETING CORPORATE SUPPORTERS

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ADDITIONAL SUPPORT

Olympus Corporation of the Americas

General Information

The American Head and Neck Society's 2013 Annual Meeting

April 10 - 11, 2013

JW Marriott Grande Lakes

4040 Central Florida Parkway, Orlando, FL 32837

COSM Registration Hours Mediterranean Foyer, Lobby Level

Wednesday, April 10	6:30 AM - 5:00 PM
Thursday, April 11	7:00 AM - 5:00 PM
Friday, April 12	7:00 AM - 5:00 PM
Saturday, April 13	7:00 AM - 3:00 PM
Sunday, April 14	7:00 AM - 10:00 AM

COSM Exhibit Hall Hours Coquina Ballroom, Lobby Level

Thursday, April 11	9:00 AM - 4:00 PM
Friday, April 12	9:00 AM - 4:00 PM
Saturday, April 13	9:00 AM - 4:00 PM

COSM Speaker Ready Room Hours Cordova 4, Lower Level

Tuesday, April 9	4:00 PM - 8:00 PM
Wednesday, April 10	6:00 AM - 6:00 PM
Thursday, April 11	6:00 AM - 6:00 PM
Friday, April 12	6:00 AM - 6:00 PM
Saturday, April 13	7:00 AM - 6:00 PM
Sunday, April 14	7:00 AM - 10:00 AM

COSM Spouse Lounge Hours Segura 5, Lower Level

Wednesday, April 10	8:00 AM - 2:00 PM
Thursday, April 11	8:00 AM - 2:00 PM
Friday, April 12	8:00 AM - 2:00 PM
Saturday, April 13	8:00 AM - 2:00 PM
Sunday, April 14	8:00 AM - 12:00 PM

COSM Shuttle Buses

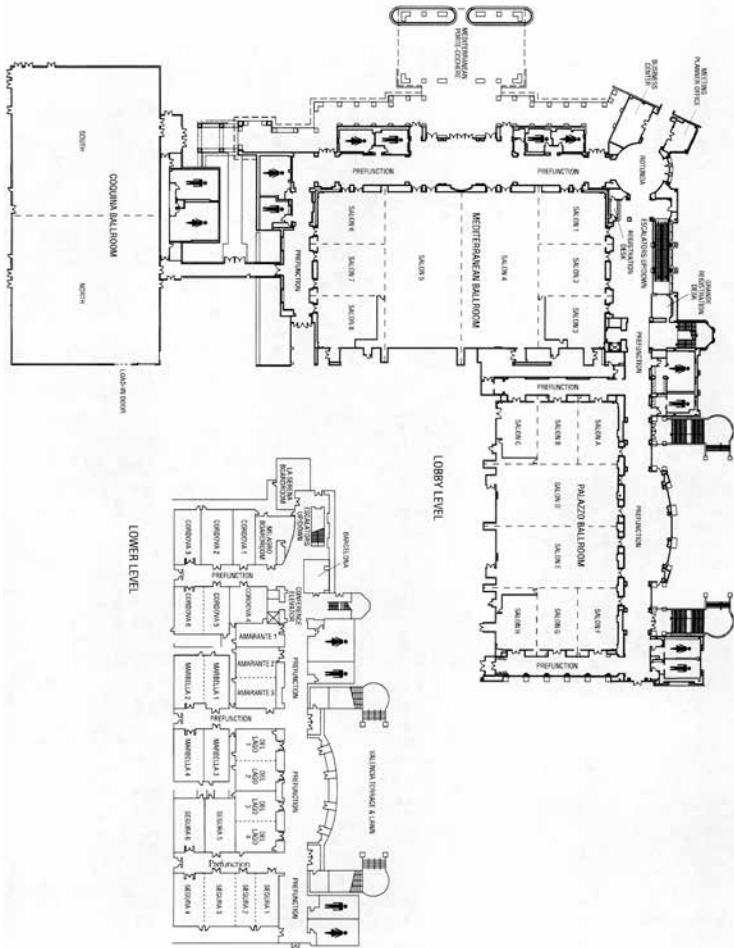
Shuttle buses between the JW Marriott Grande Lakes and the Renaissance SeaWorld Resort will be provided on an hourly and daily basis. The shuttles will pick up and drop off attendees at the Mediterranean Ballroom Entrance.

Wednesday, April 10	6:30 AM - 10:00 PM
Thursday, April 11	6:30 AM - 10:00 PM
Friday, April 12	6:30 AM - 10:00 PM
Saturday, April 13	6:30 AM - 11:00 PM
Sunday, April 14	6:30 AM - 1:00 PM

Official Language

The official language of the conference is English. Simultaneous translation will not be offered.

JW Marriott Grande Lakes Floorplan



SAVE THE DATE! AHNS FUTURE MEETING SCHEDULE

5th World Congress of the International Federation of Head & Neck Oncologic Societies (IFHNOS) combined with 2014 AHNS Annual Meeting
July 26 - 30, 2014 • New York Marriott Marquis • New York, New York

AHNS 2015 Research Workshop

Fall 2015 • Location TBD

AHNS 2015 Annual Meeting

During the Combined Otolaryngology Society Meetings

April 22 - 26, 2015 • Sheraton Boston • Boston, Massachusetts

AHNS 9th International Conference on Head and Neck Cancer

July 16 - 20, 2016 • Washington State Convention Center • Seattle, Washington

AHNS 2017 Annual Meeting

During the Combined Otolaryngology Society Meetings

April 26 - 30, 2017 • Manchester Grand Hyatt • San Diego, California

General Information

AHNS 2013 Annual Meeting Educational Objectives

The conference is designed to facilitate discussion regarding the approaches used in the diagnosis, treatment, and rehabilitation of head and neck neoplasms throughout the world. Participants should accomplish the following at the conclusion of this event:

- Understand the clinical uses of new novel molecular agents in the management of head and neck cancer;
- Understand the role of surgery, radiation therapy, chemoradiation, and combined modality therapy in the treatment of head and neck cancer as defined by results from randomized control trials;
- Understand the appropriate use of transoral approaches to remove tumors of the oropharynx;
- Understand the impact of treatment on functional outcome of head and neck cancer patients;
- Understand novel approaches to head and neck reconstruction.

AHNS 2013 CME Credit Claim Process

Please use the worksheet on page 34 to track the number of CME hours you attend for each activity. After the meeting, an email will be sent to attendees with a link to the on-line survey and claim form.

To Receive Your CME Credit:

AHNS has instituted a process for claiming CME credits and printing certificates. All attendees wishing to receive a CME certificate for activities attended at the AHNS 2013 Annual Meeting must first complete an on-line meeting evaluation form. Attendees will have access to the on-line form via link on the AHNS website after the meeting.

Please allow 4-6 weeks for processing before your certificate arrives.

Attendance Certificates

Attendees in need of an attendance certificate instead of a certificate with your CME hours may ask for one at the AHNS Desk.

AHNS Foundation/Centurion Club Lounge

Amarante 1

Wednesday, April 10	9:00 AM - 5:00 PM
Thursday, April 11	9:00 AM - 5:30 PM

About the American Head and Neck Society

Mission Statement

The purpose of this society is to promote and advance the knowledge of prevention, diagnosis, treatment and rehabilitation of neoplasms and other diseases of the head and neck, to promote and advance research in diseases of the head and neck, and to promote and advance the highest professional and ethical standards.

Why Join the AHNS?

The American Head and Neck Society is an organization of physicians, scientists and allied health professionals dedicated to improving the understanding of Head and Neck Cancer and the care of patients afflicted with that disease. Membership is open to a wide variety of interested individuals in several categories that differ both in terms of responsibility and level of involvement in the society.

For more information about AHNS membership and to apply on-line, please visit www.ahns.info/membercentral, call +1-310-437-0559, ext. 110 or ask at the AHNS desk for additional information.

The Benefits of AHNS Membership:

- Interaction with colleagues dedicated to promoting and advancing the knowledge of prevention, diagnosis, treatment, and rehabilitation of neoplasms and other diseases of the head and neck
- Member rates on all meeting registration fees
- The honor of being a part of our worldwide network of surgeons, physicians and health care professionals dedicated to the prevention and treatment of head and neck cancer
- Opportunities to partake in educational offerings, including those planned by the society and those co-sponsored by the society

- Opportunity to post regional meetings and courses on the AHNS "Related Meetings" web page
- Access to the AHNS member contact information in the "Members Only" section of our web site
- E-newsletter with updates about the society and head & neck surgery
- Ability to apply for research grant awards offered yearly
- Opportunity to participate on committees and to vote at the annual business meeting

Qualifications for Active Fellowship:

Surgical Applicants must be Diplomats of the American Board of Otolaryngology, Plastic Surgery, or Surgery or **OTHER EQUIVALENT CERTIFICATION BOARD**. Additionally, all applicants must be Fellows of the American College of Surgeons, Fellows in the Royal College of Surgeons (FRCS) or equivalent non-surgical organization.

Qualifications for Associate Fellowship:

An applicant for Associate Fellowship must be a physician, dentist, or scientist who has special interest contributions in the field of neoplastic or traumatic diseases of the head and neck.

Qualifications for Candidate Fellowship:

The trainee currently enrolled in an approved residency program in Otolaryngology, Plastic Surgery, or General Surgery or in a Fellowship program approved by the Advanced Training Council may become a Candidate Fellow.

Qualifications for Corresponding Fellowship:

An Applicant for Corresponding Fellowship must be a physician who specializes in the treatment of head and neck cancer, who by their professional associations and publications, would appear in the judgment of Council to be qualified to treat head and neck cancer. Corresponding Fellows must reside in a country other than the United States or Canada.

Deadline for the 2014 cycle is October 31, 2013

AHNS Audience Response Instructions

****NEW** Audience response system for 2013.**

Use your phone, tablet or laptop to text, tweet or post to pollev.com/ahns

Your privacy is protected! AHNS will not collect your cell phone number. You will NOT receive any text messages after the meeting.

Standard texting rates apply: it may be free if you have a text plan, or up to US\$0.20 on some carriers if you do not have a text messaging plan.

Reminder to keep cell phones on silent! Thank you.

INSTRUCTIONS

How To Vote via Texting

How do you like my presentation so far?

Text a **CODE** to **37607**

Amazing **458456**

Incredibly Amazing **458471**

It's Alright **458472**

0 1 2 3

EXAMPLE

1. Standard texting rates only (worst case US \$0.20)
2. We have no access to your phone number
3. Capitalization doesn't matter, but spaces and spelling do

TIPS

The graphic illustrates the voting process. It shows a poll question: "How do you like my presentation so far?". Below the question is a bar chart showing the number of votes for three categories: "Amazing" (458456), "Incredibly Amazing" (458471), and "It's Alright" (458472). The x-axis of the bar chart is labeled 0, 1, 2, 3. To the right of the bar chart is a smartphone screen showing a text message interface. The recipient number is 37607, and the message content is 458456. A callout box labeled "EXAMPLE" points to the code 458456 in the text message.

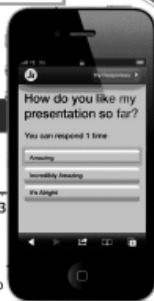
AHNS Audience Response Instructions

How To Vote via PollEv.com/ahns

How do you like my presentation so far?

Submit responses at **PollEv.com/username**

Text a **CODE** to **37607**



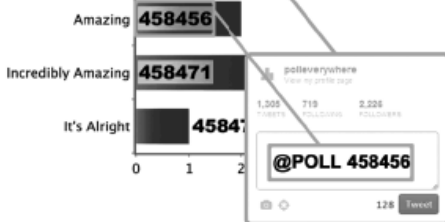
TIP Capitalization doesn't matter, but spaces and spelling do

How To Vote via Twitter

How do you like my presentation so far?

Text a **CODE** to **37607** Tweet @poll and a **CODE**

Submit responses at **PollEv.com/username**



- TIPS**
1. Capitalization doesn't matter, but spaces and spelling do
 2. Since @poll is the first word, your followers will not receive this tweet

AHNS President

Mark K. Wax, MD



Dr. Mark K. Wax received his undergraduate degree from the University of Toronto. Following his Otolaryngology training he pursued private practice in Canada. Desiring to get more advanced training, he left private practice and completed a fellowship in Advanced Head and Neck Oncologic Reconstructive Surgery at the University of Toronto. He then moved to the University of West Virginia where he established a busy Head and Neck Oncologic reconstructive practice. He continued to develop his

interests in the field of Head and Neck Surgery. He was recruited to develop and lead the Head and Neck program at SUNY Buffalo. After a few years he moved to become a full professor and Director of the Microvascular Reconstructive Program at OHSU. While at OHSU he developed the Microvascular and Reconstructive Fellowship Program that has graduated 13 fellows, with the majority going on to academic careers.

Dr. Wax has been intimately interested in academic medicine since re-entering the academic world. He is a well renowned educator, visiting more than 20 institutions as a visiting professor. He has published over 180 articles in the peer reviewed literature with contributions to more than 8 textbooks. Dr. Wax has focused his career on reconstructive surgery and developed many innovative reconstructive techniques while critically evaluating many aspects of reconstructive surgery.

His interest in the American Head and Neck Society goes back more than two decades. While always an active member of the society he joined the leadership by participating in the audit and finance committee. This was followed by a six-year term as treasurer. This was an exciting time as it saw the expansion of the society and the formalization of many budgetary processes. He was elected Vice President in 2009 and is now the President of the American Head and Neck Society. Education and the advancement of Head and Neck Oncologic and Reconstructive Surgery remains his focus.

Dr. Wax is married to Roberta Guild-Wax and has two wonderful children, Blair and Stephanie, who both attend college in Washington D.C.

About the American Head and Neck Society

History of the Society

On May 13, 1998, The American Head and Neck Society (AHNS) became the single largest organization in North America for the advancement of research and education in head and neck oncology. The merger of two societies, the American Society for Head and Neck Surgery and the Society of Head and Neck Surgeons, formed the American Head and Neck Society.

The contributions made by the two societies forming the AHNS are significant in the history of surgery in the United States. Dr. Hayes Martin conceived the Society of Head and Neck Surgeons in 1954, a surgeon considered by many to be the "father of modern head and neck tumor surgery." The purpose of the society was to exchange and advance the scientific knowledge relevant to the surgery of head and neck tumors (exclusive of brain surgery) with an emphasis on cancer of the head and neck. Two years later, The American Society for Head and Neck Surgery was organized with the goal to "facilitate and advance knowledge relevant to surgical treatment of diseases of the head and neck, including reconstruction and rehabilitation; promote advancement of the highest professional and ethical standards as they pertain to the practice of major head and neck surgery; and to honor those who have made major contributions in the field of head and neck surgery, or have aided in its advancement."

The new Society remains dedicated to the common goals of its parental organizations.

2013 Program Chair

Eben L. Rosenthal, MD



Dr. Eben L. Rosenthal received his undergraduate degree from Haverford College in 1988 and graduated with honors from University of Michigan Medical School, where he also completed his residency in Otolaryngology. After completing a fellowship in facial and plastic and reconstructive surgery at Oregon Health Sciences University, Dr. Rosenthal joined the Division of Otolaryngology at UAB. Dr. Rosenthal is

certified by the American Board of Otolaryngology and is a Diplomate of the American Board of Facial Plastic and Reconstructive Surgery. His clinical interest is in the reconstruction of head and neck defects using local, regional and microvascular free flap techniques.

In 2012, Dr. Rosenthal became Division Director of Otolaryngology – Head and Neck Surgery and the holder of the John S. Odess Endowed Chair at the University of Alabama at Birmingham. He serves as an Associate Editor for *Head & Neck* and is a founding member of the NIH Developmental Therapeutics Study Section. He has published over 100 peer-reviewed scientific and clinical manuscripts and co-authored many book chapters.

He has focused his career on translational research in head and neck cancer. He has received grant funding from the American Cancer Society, NIH/NCI and NIH/NIDCR to study the role of optical imaging in surgical resections. Translating this technology to treat a variety of cancers has become a major focus of his laboratory. His laboratory also focuses on tumor stromal interactions in the promotion of head and neck cancer and the role of targeted therapy in head and neck cancer. He has received R01 funding from the NIH/NCI to study the role of CD147 targeted therapy alone and in combination with conventional therapy to treat head and neck cancer. To facilitate clinical translation of targeted therapy, he is principal investigator on multiple investigator-initiated and industry sponsored clinical trials.

He is married to Mary T. Hawn, MD, MPH, Professor of Surgery at UAB, with whom he has two children, Sarah and Walker.

2013 Poster Chair

Karen T. Pitman, MD



Karen T. Pitman MD FACS is a native of the Maryland suburbs of Washington DC and a graduate of the University of Maryland where she received a BS in Zoology. She then worked at the NIH as a research assistant in the Section on Neurotoxicology. Time after work was spent as a volunteer at a local fire department where she obtained certification as a paramedic. The sum of these experiences sparked a keen interest in medicine and the US Navy provided the means to fulfill her dream of becoming a physician. She is a graduate of the Uniformed Services University of the Health Sciences in Bethesda, MD and served on active duty in the US Navy for 17 years. She completed her Otolaryngology residency at Naval Medical Center Portsmouth VA, followed by fellowship training in Head and Neck Surgery at the University of Pittsburgh School of Medicine. Her commitment to the US Navy was fulfilled aboard the USS Emory S. Land as a general medical officer before residency, and later as an otolaryngologist at NMC Portsmouth VA. In addition to her busy clinical practice, she was actively involved with otolaryngology resident training and research while on active duty. She was honorably discharged from the Navy and the recipient of several awards, including 2 commendation medals.

The next phase of her career took her to the Department of Otolaryngology at the University of Mississippi Medical School, advancing to Professor of Otolaryngology. There, she initiated the multidisciplinary head and neck treatment team and oversaw its' growth and development for over 10 years. In that role she recruited all the members of a dynamic and energetic treatment team, chaired a vibrant head and neck tumor conference, and oversaw the research efforts of the group serving as PI or Co-PI on numerous institutional and multi-institutional studies carried out during her tenure. As the only tertiary care facility and the sole location for comprehensive head and neck cancer care in Mississippi, her clinical practice was busy and varied, focusing on all aspects of head and neck surgery. All along she was actively involved in resident education and she was the medical student director, overseeing the department's educational activities for all levels of medical student otolaryngology exposure.

Research interests focus on evaluation and management of the clinically negative neck and institutional reviews, studying treatment outcomes at the University of Mississippi. Academic service includes leadership roles in both the American Head and Neck Society and American Academy of Otolaryngology, Head and Neck Surgery Foundation. She serves on the editorial board of the Laryngoscope and American Journal of Otolaryngology, is an Associate Editor for Head and Neck and a member of the Triological Society, completing her thesis in 2001. She served as president of the Mississippi Society of Otolaryngology. Recent awards and honors are the AAO-HNSF Distinguished Service award in 2012, Castle Connolly America's Top Doctors Award for 5 consecutive years and Castle Connolly America's Top Doctors for Cancer. A new career phase recently started at Banner-MDACC in Phoenix, Arizona as one of 2 surgeons spearheading the development of the Head and Neck Treatment program.

Hayes Martin Lecturer

Jonas T. Johnson, MD



Jonas T. Johnson is Professor and Chairman of the Department of Otolaryngology at the University of Pittsburgh School of Medicine where he holds a joint appointment as professor of Radiation Oncology. He is also professor of oral maxillofacial surgery in the School of Dental Medicine. Dr. Johnson limits his clinical practice to the treatment of patients with tumors of the head and neck as well as the diagnosis and therapy of snoring and obstructive sleep apnea.

Dr. Johnson was an undergraduate at Dartmouth College. He earned his medical degree at SUNY Update Medical Center. He later completed his residency at the same institution.

Dr. Johnson has developed his research around the care of patients with cancer of the head and neck. He has special interest and expertise in the management of patients with carcinoma of the upper aerodigestive tract as well as neoplasia of the salivary apparatus and thyroid surgery. He has a major interest in the management of cervical metastasis, surgical therapy for early laryngeal cancer, and adjuvant therapy for advanced head and neck cancer. In 1980, a prospective database of all patients treated for head and neck cancer was established at the University of Pittsburgh. This allowed for an extended period of practice-based learning, which resulted in the publications of over 500 manuscripts in the peer-reviewed literature. Dr. Johnson has contributed 175 chapters to textbooks and edited or co-edited 21 texts.

Dr. Johnson is a past president of the American Academy of Otolaryngology- Head & Neck Surgery (2003) and the American Head & Neck Society (2004). He is the past editor of the Laryngoscope (2004-2011) and President Elect of the Trilogic Society.

Past Hayes Martin Lecturers

Gregory T. Wolf, MD (2012)
Randal S. Weber, MD (2011)
Adel El-Naggar, MD (2010)
Charles W. Cummings, MD (2009)
Waun Ki Hong, MD (2008)
Jesus E. Medina, MD (2007)
Keith S. Heller, MD (2006)
Richard K. Reznick, MD, MEd (2005)
Christopher J. O'Brien, MD (2004)
Michael Johns, MD (2003)
Eugene Myers, MD (2002)
William Wei, MS (2001)
Robert M. Byers, MD (2000)
Jean-Louis H. LeFebvre, MD (1999)
Jatin P. Shah, MD (1998)
Blake Cady, MD (1997)
Joseph N. Attie, MD (1996)
Helmuth Goepfert, MD (1995)
John G. Batsakis, MD (1994)
Ronald H. Spiro, MD (1993)
John M. Lore, MD (1992)

Ian Thomas Jackson, MD (1991)
Alando J. Ballantyne, MD (1990)
George A. Sisson, MD (1989)
M.J. Jurkiewicz, MD (1988)
Elliot W. Strong, MD (1987)
Donald P. Shedd, MD (1986)
Alfred S. Ketcham, MD (1985)
William A. Maddox, MD (1984)
John J. Conley, MD (1983)
Milton Edgerton, MD (1982)
Richard H. Jesse, MD (1981)
Condit Moore, MD (1980)
Edward F. Scanlon, MD (1979)
Harvey W. Baker, MD (1978)
Harry W. Southwick, MD (1977)
Edgar L. Frazell, MD (1976)
Charles C. Harrold, MD (1975)
Arthur G. James, MD (1974)
Oliver H. Beahrs, MD (1973)
William S. MacComb, MD (1972)

Hayes Martin Biography

Hayes Martin, MD



Hayes Martin was born in Dayton, a small town in north central Iowa. He attended the University of Iowa at Iowa Falls before being accepted to the medical school in 1913 on the same campus, finishing 4 years later in a class of 20.

World War I began in April 1917 while Hayes was in his final year of medical school. Many of his classmates at the medical school were in the Army ROTC units; however, Dr. Martin opted for the Navy, which he joined on the day America entered the war. He traveled to Europe on the USS Arkansas and was assigned to his permanent duty station at the U.S. Navy Air Station, La Trinite Sur Mer, France – a small seaside village on the southern coast of Brittany. The purpose of this base was antisubmarine warfare using blimps and kite balloons. Dr. Martin was made commanding officer of the air station for a brief period of time when the line officer in charge had become ill; it was a unique position for a medical officer in the Navy to take command during wartime.

After the war, Dr. Martin returned to the U.S and sought out an internship at the old Poly Clinic Hospital in New York City, which was temporarily made into a Veteran's Administration hospital. Part of his internship was spent at Bellevue in the fourth surgical division, where he felt he would have the best possible training in general surgery. The chief of the second division was John A. Hartwell, MD, the distinguished surgeon memorialized by the Fellow's Room in the library of the New York Academy of Medicine. Dr. Hartwell suggested that Dr. Martin go to Memorial Hospital to learn about cancer.

Dr. Martin received an internship at Memorial in the summer of 1922 and stayed on as a resident until 1923. He then had two years at the second surgical service at Bellevue, where he operated to his heart's content and got the surgical education he so strongly desired. Once he finished his residency, Dr. Martin returned to Memorial where he joined as clinical assistant surgeon on the staff.

Dr. Martin made the use of aspiration biopsy on all solid tumors popular throughout Memorial. Now, this procedure is done throughout the world. Dr. Martin co-authored the first report on the subject published in the *Annals of Surgery*. Numerous other articles followed, including Dr. Martin's two most famous publications, "Cancer of the Head and Neck," published in two issues of the *Journal of the American Medical Association* in 1948, and "Neck Dissection," appearing in *Cancer* in 1951. These two papers were so extensively requested that the American Cancer Society made reprints by the thousands available to those who requested them as many as 20 years after publication. Dr. Martin's bibliography encompasses more than 160 articles.

In 1934, Dr. Martin was appointed Chief of the Head and Neck Service at Memorial Hospital. It wasn't until 1940 that surgery began to take over as the treatment of choice for the majority of cancers of the head and neck. In that year, the beginnings of improved anesthesia permitted advances in surgery. Later, during World War II, antibiotics became available and surgery began to dominate much of head and neck cancer management. Dr. Martin wrote extensively on many subjects, most within the realm of head and neck surgery. His ideal was to be the complete head and neck surgeon and he treated a wide variety of head and neck abnormalities. His book, *Surgery of the Head and Neck Tumors*, was published in 1957.

Dr. Martin retired from active practice in 1957 at the age of 65. He performed his last operation at Memorial Hospital, assisted by Dr. Elliot Strong, in October 1959, but continued to see patients in his office until he passed away in 1977.

John J. Conley Lecturer

Patrick J. Gullane, CM, MB, FRCSC, FACS, FRACS (Hon), FRCS (Hon), FRCSI (Hon)



Professor Patrick Gullane was born in Ireland and received his medical degree from Galway University, Ireland in 1970. He is a Fellow of the Royal College of Surgeons of Canada and certified by the American Board of Otolaryngology-Head and Neck Surgery. In 1975 he was selected as the McLaughlin Fellow and then pursued advanced training in Head and Neck Oncology in Pittsburgh, and New York.

In 1978 Dr. Gullane was appointed to the Department of Otolaryngology-Head and Neck Surgery at the University of Western Ontario. He was subsequently recruited to the Department of Otolaryngology-Head and Neck Surgery at the University of Toronto in 1983. In 1989 he was appointed as Otolaryngologist-in-Chief within the University Health Network and in 2002 appointed as Professor and Chair of the Department of Otolaryngology-Head and Neck Surgery, University of Toronto. He concluded his second and final term as Chair in June 2012.

Dr. Gullane is a member of numerous Surgical Societies, nationally and internationally, and has been invited as a Visiting Professor to over 65 countries lecturing on all aspects of Head and Neck Oncology. He has delivered over 770 presentations nationally/internationally and serves on the Editorial Board of 10 Journals. Dr. Gullane has published 281 papers in peer-reviewed journals and 73 chapters in textbooks. In addition he has published 9 books on various aspects of Head and Neck Surgery.

Dr. Gullane has been a PI or collaborator on numerous research grants (10 ongoing) receiving funding from various Agencies, including NCIC and NIH.

Honours/Awards

- 2012 Recipient of the Royal College of Surgeons in Ireland Honorary Fellowship (RCSI), Ireland Feb 2012
- 2011 Election to Fellowship in the Canadian Academy of Health Sciences (CAHS) Induction- Ottawa Sept 2011
- 2011 Recipient of the "Teacher of the Year Award" - Department of Otolaryngology-Head and Neck Surgery - University of Toronto- June 2011
- 2011-12 Vice-President Elect - Canadian Society of Otolaryngology-Head and Neck Surgery (CSO-HNS)
- 2011 Guest of Honour - 65th Annual CSO-HNS Meeting, Victoria BC May 2011
- 2010 Appointed as a Member to the Order of Canada by the Governor General of Canada: Cited for his inspiration of young surgeons and his contributions to the field of Head and Neck Surgery
- 2010 Recipient of Royal College of Surgeons of England Honorary Fellowship (FRCS), London England
- 2008 Invited Faculty - 1st Educational World Tour (11 countries) - International Federation of Head and Neck Oncologic Societies - Current Concepts in Head and Neck Surgery and Oncology
- 2006 Recipient of the Royal Australasian College of Surgeons Honorary Fellowship (FRACS), Sydney Australia
- 2005-06 Served as Vice-President, Triological Society (Eastern Section)
- 2004-05 Served as President, the North American Skull Base Society
- 2004-05 Served as President, the American Head and Neck Society
- 1998 Facilitated the establishment of four University-Hospital Chairs: Head & Neck Surgery, Reconstruction, Radiation Oncology, and Basic Science, from private funding donations in excess of \$14.5 M. - with continual funding up to the present time

John J. Conley Biography

John J. Conley, MD



Although he looked and sounded like an English nobleman, Dr. John Conley was born in Carnegie, Pennsylvania, a small steel mill town just outside of Pittsburgh. He graduated from the University of Pittsburgh and later its school of medicine. He interned at Mercy Hospital in Pittsburgh. During that year, the nuns who ran the hospital suggested that Dr. Conley take a residency in cardiology and come back to Mercy as their cardiologist.

He went to Kings County Hospital in Brooklyn, a very busy city hospital with a huge patient population. Shortly after he began his training, he had an arrhythmia diagnosed as paroxysmal atrial tachycardia. Little was known about this benign condition at that time. Dr. Conley was told that cardiology was too stressful and that he should go into an easier, less-stressful field with better working hours, like ENT. He did an otolaryngology residency at Kings County Hospital. This was followed by four years of military service during World War II, which included experience in otolaryngology and plastic and reconstructive and maxillofacial surgery in the U.S. Army Medical Corps, both in this country and in the South Pacific theater. Exposure to the construction of war wounds would prove invaluable to him later on in applying these principles to reconstruction following ablative head and neck surgery.

Dr. Conley returned to New York City after the war. He became an assistant and then an associate of Dr. George T. Pack, a technically superb general oncologic surgeon at Memorial Hospital who taught Dr. Conley major ablative surgery of the head and neck. They worked day and night catching up with the backlog of surgery that was neglected during the war years. The combination of his training in otolaryngology, the exposure to ablative surgery, and the World War II experience in reconstructive surgery set the stage for Dr. Conley to evolve his unique approach to head and neck surgery.

Ironically, despite the admonition of the cardiologists about hard work, Dr. Conley did a prodigious amount of major head and neck reconstructive surgery. This proved to be more than ample to provide training to many fellows. His commitment to education is further attested to by the position he held for many years as Clinical Professor of Otolaryngology at the College of Physicians and Surgeons at Columbia University. He loved his appointment at Columbia and particularly his involvement in teaching the residents.

Dr. Conley's vast surgical experience, together with active research interests, led to the authorship of almost 300 contributions to the scientific literature, and eight books. As a result of his productivity and rhetorical eloquence, he was very much in demand as a speaker in this country and abroad. He gave many prestigious eponymous lectures in our field and received many awards for his work, including the Philip H. Hench Award as the Distinguished Alumnus of the University of Pittsburgh School of Medicine, and the DeRoaldes and Newcomb Awards of the American Laryngological Association.

Dr. Conley's contributions to the scientific literature, many technical innovations and surgical experience placed him in the position to receive many honors and important leadership positions, such as President of the American Academy of Otolaryngology and Ophthalmology, member of the Board of Governors of the American College of Surgeons, founding member of the Society of Head and Neck Surgeons, and founding member and first President of the American Society for Head and Neck Surgery. During those years, Dr. Conley used, to the great benefit of us all, his wisdom and diplomacy in carrying out such high-level responsibilities.

Past John J. Conley Lecturers

Julie A. Freischlag, MD (2012)
Benjamin S. Carson, Sr., MD (2011)
Robert L. Comis, MD (2010)
James D. Smith, MD (2009)
Carolyn Dresler, MD (2008)
Kenneth I. Shine, MD (2007)

John Stone, MD, MACP (2006)
James F. Battey Jr., MD (2005)
David C. Leach, MD (2004)
Jonathan D. Moreno, MD (2003)
Rabbi David Saperstein (2002)
Edward Hughes, MD (2001)

Jatin P. Shah Symposium & Biography



Professor Jatin P. Shah graduated from the Medical College of MS University in Baroda, India, and received his training in Surgical Oncology and Head and Neck Surgery at Memorial Sloan Kettering Cancer Center. He is Professor of Surgery, at the Weil Medical College of Cornell University, and Chief of the Head and Neck Service, Leader of the Head and Neck Disease Management Team, and holds The Elliott W. Strong Chair in Head and Neck Oncology at Memorial Sloan-Kettering Cancer Center in New York City.

Dr. Shah is a national and international leader in the field of head and neck surgery, having served as President of The New York Cancer Society, The New York Head and Neck Society, The Society of Head and Neck Surgeons, The North American Skull Base Society and the International Academy of Oral Oncology. He is Founder of The International Federation of Head and Neck Oncologic Societies, in 1986. He currently serves as Chairman of the AJCC task force on Head and Neck. He was Chairman of the Joint Council for advanced training in head and neck oncologic surgery in the USA. He was also Chairman of the 4th International Conference on Head and Neck Cancer in Toronto in 1996. He has served in varying capacities for The American Board of Surgery, and the American College of Surgeons.

Professor Shah has been the recipient of numerous awards from various parts of the world, and is the recipient of honorary fellowships from The Royal College of Surgeons of Edinburgh, London and Australia. He holds Honorary PhD, degrees from the Catholic University of Louvain, in Belgium and the University of Athens, in Greece. He is recipient of the Blokhin Gold medal, the highest Honor in Oncology in Russia. He has been elected as an honorary member of several head and neck societies in Europe, Asia, Australia, Africa and Latin America. He has been continuously listed in the "Best Doctors in America" directories for several years. He serves on the Editorial and Review Boards of 18 scientific journals and has published over 300 peer-reviewed articles, 50 book chapters and 7 books. His textbook of Head and Neck Surgery and Oncology won First Prize from The British Medical Association and The Royal Society of Medicine and was awarded the George Davey Howells Prize from the University of London, for the best published book in otolaryngology in the preceding five years.

He is a much sought after speaker who has delivered over 1,000 scientific presentations including, 59 eponymous lectures and keynote addresses, and visiting professorships in the United States, Canada, United Kingdom, Scotland, Sweden, Belgium, Germany, Italy, Spain, Poland, Russia, Croatia, Turkey, Egypt, South Africa, India, China, Korea, Japan, Hong Kong, Taiwan, Singapore, Phillipines, Australia, Argentina, Brazil, Chile, Peru, Equador, Venezula, Panama, and Mexico.

In recognition of his outstanding contributions, and World Leadership in Head and Neck Surgery, Memorial Sloan Kettering Cancer Center, has established The "Jatin Shah Chair in Head and Neck Surgery and Oncology", The International Federation of Head and Neck Oncologic Societies has established "The Jatin Shah Lecture", at its world congresses, and the American Head and Neck Society has established the "Jatin Shah Symposium" at its annual meeting.

Guest of Honor

T. David R. Briant, FRCS(C), FACS



Dr. Briant was born in Toronto Ontario Canada. He was educated at Ridley College and later at the University of Toronto. He graduated as an M.D. in 1955 passing his Canadian examinations and his National State Board examinations. He did a post graduate course in General Surgery under Dr Professor. F.G. Kergin and worked with Dr. Robert Mustard and Dr. John Palmer noted general surgeons specializing in head and neck

surgery and often scrubbed with Dr. Harold Wookey of the Wookey Procedure. This was followed by a postgraduate course in Otolaryngology Head and Neck Surgery under Percy Ireland. He completed the examinations of the Royal College of Surgeons of Canada in Otolaryngology in 1961. He then did a Fellowship at the Middlesex Hospital in London England under Mr. C.P Wilson and spent time with Mr. Angel James learning Trans –Sphenoidal Hypophosectomy.

He became a staff member of the Toronto General Hospital (now part of the University of Toronto Network) for ten years. In 1964 he became a Consultant at the Ontario Cancer Institute, Princess Margaret Hospital and Sunnybrook Hospital. He then transferred to St. Michaels Hospital becoming Chief of the Department of Otolaryngology of the hospital.

In 1966, he became a Fellow of the American college of Surgeons. In 1986, he became Head of the Division of Head and Neck Surgical Oncology of the Department of Otolaryngology at the University of Toronto.

He has published 76 learned papers and written two chapters in books as well as doing an award winning movie. He also took a keen interest in facial plastic surgery and was an early adopter of the external approach rhinoplasty.

He was a member of Council of the American Society of Head and Neck Surgery from 1986- 89 and was involved in many other societies pertaining to the region. He mentored 13 fellows practically all recognized by the program of the American Society of Head and Neck Surgery; your present president being one of them and perhaps the most productive of the group.

His hobbies included painting and flying, owning a number of planes. Since retirement he spends the winters in Costa Rica and his summers at his cottage on Lake of Bays in the Muskoka region of Ontario and the opera season spring and fall in Toronto at the newish Four Seasons Opera House. He is married to a college professor of economics and singer for better than 55 years and has three children who all live nearby. There are four grand children, two boys and two girls, one of who graduated with Honours from University and hopes to go into medicine.

Distinguished Service Award

Dennis H. Kraus, MD



Dr. Dennis Kraus is the Director of the Center for Head and Neck Oncology within the New York Head and Neck Institute and the North Shore-LIJ Cancer Institute. He has served in a number of administrative positions within otolaryngology and head and neck surgery. He has served in multiple positions within the AHNS including program chair of the annual meeting and secretary. He serves as a member of the Board of

Governors for the American College of Surgeons and the Otolaryngology Advisory Council. He is the past president of the North American Skull Base Society, the New York Head and Neck Society and the New York Laryngological Society. He is currently the co-editor in chief of the Skull Base Journal and associate editor of Head and Neck Surgery. He is a member of the Subspecialty Advisory Council for the American Association of Otolaryngology-Head and Neck Surgery and is past chair of the Head and Neck Educational Committee. His clinical interest focus on all aspects of head and neck oncology and his research efforts have parallel his clinical initiatives. He has been fortunate to lecture across both the USA and around the world in a number of venues.

He is very honored to be the recipient of this prestigious award. On a personal level, he is married to his wife of 25 years, Daryl, and all 3 of his children are currently attending college. He continues to enjoy golf, skiing and travel.

Past Distinguished Service Award Recipients

Jatin P. Shah, MD 1989

Stephan Ariyan, MD 1990

Ashok R. Shaha, MD 1991

Elliot W. Strong, MD 1995

John J. Coleman, III MD 1999

David L. Larson, MD 1999

Harold J. Wanebo, MD 1999

Jonas T. Johnson, MD 2001

Helmuth Goepfert, MD 2003

Marc D. Coltrera, MD 2004

Wayne Koch, MD 2005

John A. Ridge, MD, PhD 2006

Ernest A. Weymuller, Jr., MD 2007

Helmuth Goepfert, MD 2008

Keith S. Heller, MD 2009

Mark K. Wax, MD 2010

Randal S. Weber, 2011

Ashok R. Shaha, MD 2012

Past Special Recognition Award Recipients

Paul B. Chyetien, MD 1984

John M. Lore, Jr., MD 1985

William S. MacComb, MD 1986

Calvin T. Klopp, MD 1987

Edgar L. Fazell, MD 1988

Harvey W. Baker, MD 1989

Vahram Y. Bakamjian, MD 1991

Jean-Louis Lefevbre, MD 1995

Presidential Citations

Brian B. Burkey, MD



Brian B. Burkey MD FACS is currently Vice-chairman and Section Head of the Section of Head and Neck Surgery and Oncology at the Cleveland Clinic Head and Neck Institute. He also serves as Medical Director of the Center for Consumer Health Information within the Education Institute at the Cleveland Clinic, which is a group of 30 people dedicated to the production of multimedia patient health information for all medical needs of patients and

their families. Dr. Burkey came to the Cleveland Clinic after almost twenty years at Vanderbilt University Medical Center, rising to Professor of Otolaryngology and Vice-chairman within that department.

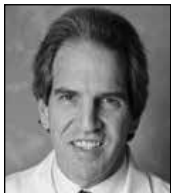
Dr. Burkey finished undergraduate studies at Johns Hopkins University, before obtaining his medical degree at the University of Virginia School of Medicine in 1986. He completed otolaryngology residency training at the University of Michigan Department of Otolaryngology and a fellowship in microvascular and facial plastic and reconstructive surgery at the Ohio State University, before launching his career at Vanderbilt. He has been an American Board of Otolaryngology diplomate since 1992, and his practice has an emphasis on head and neck oncologic and microvascular reconstructive surgery. He began co-directing the Vanderbilt fellowship in Head and Neck Oncologic and Microvascular Reconstructive Surgery starting in 1992, one of the early fellowships in microvascular surgery, and has trained 30 fellows over his career, almost all of whom have positions in academic otolaryngology both nationally and internationally. He has continued this fellowship at the Cleveland Clinic.

At Vanderbilt, Dr. Burkey served as residency Program Director for 15 years, which spanned three successful site visits. Dr. Burkey recently completed a seven-year tenure on the Otolaryngology Residency Review Committee of the ACGME, serving two years as Vice-chairman and two years as Chairman of that body. He then served as a consultant with ACGME-International and helped three programs in Singapore gain initial accreditation. He was on the steering committee which founded the Otolaryngology Program Directors Organization (OPDO), and served on the Executive Council and as President of the Society of University Otolaryngologists (SUO). He has also served as a guest examiner and senior examiner of the American Board of Otolaryngology and has been a member of the Board of Governors and numerous educational committees of the American College of Surgeons.

Dr. Burkey has been an active member of the American Head and Neck Society, serving on the Educational and Website committees, and just completed his second term on the Council, comprising over twelve years of service. He currently is the chair of the Constitution and Bylaws committee. He serves on the editorial board of multiple journals in the field of otolaryngology, and has lectured extensively on educational and clinical subjects both nationally and internationally. He has authored over 15 book chapters and 75 peer-reviewed articles on head and neck and reconstructive surgery topics. He has been a leader on several cooperative group studies and currently is a co-principal investigator of NIH-funded research. He continues to mentor residents and fellows and is hoping to continue innovation within all areas of medical education. He will complete his Masters degree in Education with an emphasis on the health professions in 2014. Dr. Burkey is married to Maureen, his wife of over 30 years, and their daughter Rachel Burkey lives and teaches in Nashville, TN.

Presidential Citations

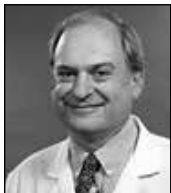
Neal D. Futran, MD, DMD



Neal D. Futran, MD, DMD joined the University of Washington faculty in 1995. He is currently the Allison T. Wanamaker Professor and Chair of the Department of Otolaryngology – Head and Neck Surgery. He is also the Director of Head and Neck Surgery as well as an adjunct professor in the departments of Plastic Surgery and Neurology Surgery. Dr. Futran earned his dentistry degree at the University of Pennsylvania and completed training in oral and maxillofacial surgery as well as an MD degree at the Health Science Center at Brooklyn, New York. He then trained in Otolaryngology – Head and Neck Surgery at the University of Rochester followed by a Head and Neck Oncology and Microvascular Surgery fellowship at Mount Sinai Hospital in New York with Dr. Mark Urken. Dr. Futran became an assistant professor in the Department of Otolaryngology at the University of South Florida in 1993 specializing in head and neck oncologic and reconstructive surgery and subsequently relocated to Seattle.

Dr. Futran is board certified in Otolaryngology and has outstanding expertise and an active practice in head and neck oncology and microvascular reconstruction and rehabilitation of complex, oncology and trauma cases. He also specializes in skull base surgery utilizing both endoscopic and open approaches. His major research activities center on microvascular reconstruction of the head and neck and he also participates in grants studying molecular profiles and gene analysis in oral carcinogenesis. He enjoys teaching on the topics of head and neck reconstruction, craniofacial trauma, skull base surgery, and head and neck oncology worldwide. He is on the board of trustees of the AO Foundation, UW Physicians, and the Virginia Bloedel Hearing Research Institute. Dr. Futran is on the editorial boards of several scientific journals and holds the position of associate editor of both *Head and Neck*, and *Oral Oncology*. He is listed in the *Best Doctor's in America*.

Paul A. Levine, MD



Born in Brooklyn, New York on November 4, 1947, Paul A. Levine, MD received a Bachelor of Science degree in Biology from Rensselaer Polytechnic Institute in 1969, his M.D. from Albany Medical College in 1973, and completed his internship and otolaryngology-head and neck surgery surgical residency at Yale in 1977. After a year fellowship at Stanford in head and neck, maxillofacial, and facial plastic and reconstructive surgery completed in 1978, Dr. Levine remained on the Stanford faculty as an assistant professor in the Division of Otolaryngology-Head and Neck Surgery as well as the associate chief for the Division at Santa Clara Valley Medical Center. In 1984, he joined the Department of Otolaryngology-Head and Neck Surgery at the University of Virginia as an associate professor and vice chair, became a tenured professor in 1987, and was named chairman of the department at UVA in 1997, a position he stills holds.

Dr. Levine has contributed over 140 publications to the specialty during his career and has been very active in institutional and national committees, in and outside the specialty throughout his career. He was an early proponent of plate fixation for mandible fractures, and he has become recognized for his expertise in treating sinonasal malignancies, especially esthesioneuroblastoma and sinonasal undifferentiated carcinoma, as well as experience in performing craniofacial resections and sparing of the eye when treating these malignancies. A nationally and internationally recognized academic head and neck cancer surgeon, Dr. Levine has served as a member of all the major societies in the field and as a leader of many. He has served as the past president of the American Broncho-Esophagological Association, chairman of the Advanced Training Council of the American Head and Neck Society as well as the President of the American Head and Neck Society. He has been a director of the American Board of Otolaryngology, completing his 12 year term in 2010 and also served as its treasurer for four years. He completed his term as Southern Section Vice President of the Triological Society in 2007 and currently serves as the editor of *JAMA Otolaryngology-Head and Neck Surgery* (formerly known as *Archives of Otolaryngology-Head and Neck Surgery*) as well as an editorial board member of *JAMA*. Dr. Levine most recently was the Guest of Honor at the Triological Society Combined Otolaryngology Sections Meeting in April 2012 and has been named the Guest of Honor for the Triological Society Southern Sections Meeting in 2013.

Presidential Citations

Jeffrey N. Myers, MD



Dr. Jeffrey N. Myers received his medical (MD) and doctoral (PhD) degrees from the University of Pennsylvania School of Medicine, and he then completed his residency training in Otolaryngology-Head and Neck Surgery at the University of Pittsburgh. He subsequently completed fellowship training in Head and Neck Surgical Oncology at the University of Texas M.D. Anderson Cancer Center, where he has been on the faculty ever since. Dr. Myers leads a basic and translational research program and his primary research interests are in

the role of p53 mutation in oral cancer progression, metastasis and response to treatment.

Dr. Myers and his wife Lisa have enjoyed 22 years of marriage and are the proud parents of three boys, Keith 21, Brett 17 and Blake 12.

Stephen Wetmore, MD, MBA, FACS



Dr. Wetmore grew up in northern Indiana and attended college and medical school at the University of Michigan where he graduated with distinction in 1971. He did his internship and a year of general surgery training in Los Angeles and then completed four years of specialty training in Otolaryngology Head and Neck Surgery at the University of Iowa. For the next eleven years, he was on staff at the University of Arkansas School of Medicine where he was a pioneer in laser surgery. From 1979 to 1982 he was an

American Cancer Society Junior Faculty Clinical Fellow under the guidance of Dr. James Suen. In 1985 he did a fellowship in neurotology and skull base surgery in Zurich, Switzerland, under the guidance of Dr. Ugo Fisch.

Dr. Wetmore came to West Virginia University in the summer of 1988 as Professor and Chairman of the Otolaryngology- Head and Neck Surgery Department. His main area of interest is in diseases of the ear including hearing loss, dizziness, tinnitus, facial paralysis, and surgery of the ear and skull base.

Dr. Wetmore has published over seventy articles and book chapters in the medical literature on subjects ranging from laser surgery to sleep apnea to approaches to skull base surgery. He is also a member of numerous professional medical societies. In 1999 he received the degree of Masters in Business Administration "to enable me to become a better leader of my department and the medical center." In 2004, he received the Distinguished Service Award from the American Academy of Otolaryngology/Head and Neck Surgery.

On a personal level, Dr. Wetmore is married and has four children all of whom are married. For relaxation, he enjoys reading, using his personal computer, and skiing.



**Congratulations to the
AHNS 2013 Award Winners!**

Presented during the AHNS Awards Ceremony

Thursday, April 11, 2013

9:45AM - 10:00AM

Robert Maxwell Byers Award

**Steven M. Sperry, MD
University of Pennsylvania**

*"Supracricoid Partial Laryngectomy for Primary and
Recurrent Laryngeal Cancer"*

Best Resident Basic Science Paper

**Chi T. Viet, DDS, PhD
New York University, Bluestone Center for Clinical Research**

*"Decitabine and Cisplatin Combination Therapy for
Head and Neck Squamous Cell Carcinoma"*

Best Resident Clinical Paper

**Gretchen M. Oakley, MD
University of Utah Health Sciences Center**

*"Significant Familial Risk in Multiple Generations of
Papillary Thyroid Carcinoma Probands"*

AHNS Leadership

Officers of the AHNS

President:	Mark K. Wax, MD
President-Elect:	Terry A. Day, MD
Vice-President:	Douglas A. Girod, MD
Secretary:	Dennis H. Kraus, MD
Treasurer:	Ehab Y. Hanna, MD
Past Presidents:	Carol R. Bradford, MD
	David W. Eisele, MD
	John A. Ridge, MD, PhD

Fellows-At-Large:

Jeffrey Bumpous, MD	Kerstin A. Stenson, MD
Daniel G. Deschler, MD	Erich M. Stugis, MD
Ralph W. Gilbert, MD	Ralph P. Tufano, MD
Cherie-Ann O. Nathan, MD	Marilene B. Wang, MD
Lisa A. Orloff, MD	

Committees of the AHNS

Ad Hoc ATC Advanced Technologies Task Force

Randal S. Weber, MD (Chair)	2011-2013	Jeffrey Scott Magnuson, MD, FACS	
Jeffrey M. Bumpous, MD	2011-2013		2011-2013
Terry A. Day, MD	2011-2013	Bert W. O'Malley, Jr., MD	2011-2013
Ramon Esclamado, MD	2011-2013	Ashok R. Shaha, MD	2011-2013

Ad Hoc CME Measurement Task Force

Greg A. Krempf (Chair)	2012-2014	Stuart Charles Coffey, MD	2012-2015
Karen T. Pitman, MD	2010-2013	Jan L. Kasperbauer, MD	2012-2015
Eben L. Rosenthal, MD	2010-2013	Rohan Ramchandra Walvekar, MD	
Paul L. Friedlander, MD	2012-2014		2012-2015
Samir Khariwala, MD	2012-2014		

Advanced Training Council (ATC)

William M. Lydiatt, MD (Chair)	2012-2014	Danny Enepekides, MD, FRCS	2010-2015
Jeffrey M. Bumpous, MD	2008-2013	Erich M. Sturgis, MD	2010-2015
Ramon Esclamado, MD	2008-2013	Douglas A. Girod, MD	2012-2017
Kerstin M. Stenson, MD	2009-2014	David A. Terris, MD, FACS	2012-2017
Neal Topham, MD	2009-2014	Donald T. Weed, MD	2012-2017

Awards Committee

D. Gregory Farwell, MD (Chair)	2010-2013	John H. Yoo, MD, FACS	2010-2013
William R. Carroll, MD	2010-2013	Miriam Lango, MD	2011-2014
Daniel G. Deschler, MD	2010-2013	John H. Lee, MD, FACS	2012-2015
Jason Hwa Yound Kim, MD	2010-2013	Yelizaveta Lisa Shnyder, MD	2012-2015

CME Compliance Committee

Paul L. Friedlanders, MD (Chair)		Samir Khariwala, MD	2012-2014
	2011-2013	Greg A. Krempf, MD	2012-2014
Dennis H. Kraus, MD (Ex Officio)		Oleg Militsakh, MD	2012-2014
	2007-2013	Joseph Scharpf, MD, FACS	2012-2014
Jeffrey N. Myers, MD, PhD	2011-2013	Marrilene B. Wang, MD	2012-2014

AHNS Leadership

Constitution and By-Laws Committee

Brian B. Burkey, MD (Chair)	2010-2013	Paul L. Friedlander, MD	2007-2013
Dennis H. Kraus, MD (Ex Officio)		Ellie Maghami, MD	2010-2013
	2007-2013	Gerry F. Funk, MD	2012-2015
Brandon G. Bentz, MD	2007-2013	M. Boyd Gillespie, MD, MS	2012-2015

Credentials Committee

Mark K. Wax, MD (Chair)	2012-2015	Joseph C. Sniezek, MD	2010-2013
Dennis H. Kraus, MD (Ex Officio)		Carol R. Bradford, MD	2012-2014
	2007-2013	Daniel G. Deschler, MD	2012-2015
David W. Eisele, MD	2010-2013		

Education Committee

David Goldenberg, MD (Chair)	2010-2013	Kavita Pattani, MD, MS	2011-2014
David I. Rosenthal, MD	2007-2013	Stuart C. Coffey, MD	2012-2015
Stephen W. Bayles, MD	2010-2013	Tamer Ghanem, MD, PhD	2012-2015
R. Bryan Bell, MD, DDS	2010-2013	Jeffrey Chang-Jen Liu, MD	2012-2015
Robert W. Dolan, MD	2010-2013	Luc G.T. Morris, MD	2012-2015
Miriam Lango, MD	2010-2013	Nitin A. Pagedar, MD	2012-2015
Neil Dwayne Gross, MD	2011-2014	Theodoros N. Teknos, MD	2012-2015
Eric Lentsch, MD	2011-2014	Terance T. Tsue, MD	2012-2015
Ellie Maghami, MD	2011-2014		

Endocrine Committee

David J. Terris, MD (Chair)	2010-2013	Brendan C. Stack, Jr., MD	2010-2013
Gary L. Clayman, MD, DDS	2007-2013	David Steward, MD	2010-2013
Gregory L. Randolph, MD	2007-2013	Eric Lentsch, MD	2011-2014
Maisie Shindo, MD	2007-2013	Glenn E. Peters, MD	2011-2014
Ralph P. Tufano, MD	2007-2013	Kevin T. Brumund, MD	2012-2015
Salvatore M. Caruana, MD	2010-2013	Maria Evasovich, MD	2012-2015
Amy Y. Chen, MD	2010-2013	Neal D. Gross, MD	2012-2015
Lisa A. Orloff, MD	2010-2013	Russell B., Smith, MD	2012-2015

Ethics and Professionalism Committee

William M. Lydiatt, MD (Chair)	2010-2013	Wayne M. Koch, MD	2010-2013
Jeffrey M. Bumpous, MD	2010-2013	Susan Dixon McCammon, MD	2010-2013
Daniel G. Deschler, MD	2010-2013	Pierre Lavertu, MD	2012-2015
M. Boyd Gillespie, MD, MS	2010-2013	Mark E.P. Prince, MD	2012-2015
Douglas A. Girod, MD	2010-2013		

Finance Committee

Cherie-Ann O. Nathan, MD (Chair)		Robert L. Ferris, MD, PhD	2011-2013
	2011-2014	Shawn D. Newlands, MD, PhD	2012-2015
Ehab Y. Hanna, MD (Ex Officio)	2010-2013		

Head and Neck Reconstructive Committee

Mark K. Wax, MD (Chair)	2012-2015	Urjeet A. Patel, MD	2011-2014
Derrick Lin, MD (Co-Chair)	2012-2015	Jeremy Richmon, MD	2011-2014
Matthew M. Hanasono, MD	2010-2013	Yelizaveta Lisa Shnayder, MD	2012-2015
Oleg Militsakh, MD	2010-2013		

History Committee

Greg A. Kreml, MD (Chair)	2012-2014	David S. Eisele, MD	2012-2014
Keith S. Heller, MD	2010-2014	Daniel D. Lydiatt, MD, DDS	2012-2014
Jonas T. Johnson, MD	2010-2014	Alan T. Richards, MD	2012-2014
Randal S. Weber, MD	2011-2013	Ralph P. Tufano, MD	2012-2014

AHNS Leadership

Humanitarian Committee

Wayne M. Koch, MD (Chair)	2009-2015	Francisco J. Civantos, MD	2011-2013
James L. Netterville, MD	2009-2015	Gregory L. Randolph, MD	2011-2013
K. Thomas Robbins, MD	2009-2015	Merry E. Sebelik, MD	2011-2013
Robert W. Dolan, MD	2010-2013	M. Boyd Gillespie, MD, MS	2012-2015
Robert A. Frankenthaler, MD	2010-2013	Joshua Hornig, MD	2012-2015
Gady Har-El, MD	2010-2013	Scharukh Jalisi, MD	2012-2015
Shawn Newlands, MD, PhD	2010-2013	Randal A. Otto, MD	2012-2015

Nominating Committee

Carol R. Bradford, MD (Chair)	2012-2013	Paul L. Friedlander, MD	2012-2013
John A. Ridge, MD, PhD	2010-2013	Bhuvanesh Singh, MD, PhD	2012-2013
David W. Eisele, MD	2011-2014		

Prevention and Early Detection Committee

Elizabeth A. Blair, MD (Chair)	2010-2013	Hadi Seikaly, MD	2010-2013
Ann M. Gillenwater, MD	2007-2013	Uttam K. Sinha, MD	2010-2013
Daniel D. Lydiatt, MD, DDS	2007-2013	Derrick Wallace, MD	2010-2013
Jay O. Boyle, MD	2010-2013	Joseph A. Califano, MD	2011-2014
Samir Khariwala, MD	2010-2013	Michael G. Moore, MD	2011-2014
Karen T. Pitman, MD	2010-2013	Cherie-Ann O. Nathan, MD	2011-2014
Eben L. Rosenthal, MD	2010-2013	Joseph Scharpf, MD	2012-2015

Program Committee

Eben L. Rosenthal, MD (Chair)	2012-2013	Kelly M. Malloy, MD	2012-2013
Amit Agrawal, MD	2012-2013	Susan D. McCammon, MD	2012-2013
Stephen W. Bayles, MD	2012-2013	Eduardo Mendez, MD	2012-2013
Brandon G. Bentz, MD	2012-2013	Oleg Militashk, MD	2012-2013
Jeffrey M. Bumpous, MD	2012-2013	Brian A. Moore, MD	2012-2013
Brian B. Burkey, MD	2012-2013	Cherie-Ann O. Nathan, MD	2012-2013
William R. Carroll, MD	2012-2013	Jason G. Newman, MD	2012-2013
Marion E. Couch, MD	2012-2013	Brian Nussenbaum, MD	2012-2013
Danny Enepekides, MD, FRCS	2012-2013	Vicente Resto, MD, PhD	2012-2013
Ramon Esclamado, MD	2012-2013	Jeremy Richmon, MD	2012-2013
Thomas Gal, MD, MPH	2012-2013	James Rocco, MD, PhD	2012-2013
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Robert Maxwell Byers Biography

Robert Maxwell Byers



The Robert Maxwell Byers Award, in the amount of \$1000, is awarded for the best clinical or basic science research paper submitted for presentation at the annual meeting of the American Head and Neck Society.

Robert Maxwell Byers, M.D. was born in Union Hospital, Baltimore, Maryland on September 24, 1937. He grew up on the Eastern Shore of Maryland in the small town of Elkton. Very active in the varsity sports of baseball, basketball and track during his high school years, he

continued his athletic participation at Duke University along with his pre-med studies. He entered the University of Maryland Medical School in Baltimore in 1959 where he excelled in his medical studies and received membership in AOA and the Rush Honor Medical Society. The highlight of his sophomore year was his 1961 marriage to Marcia Davis, his high school sweetheart. During his junior year, he was commissioned an Ensign in the United States Naval Reserve and later rose to the rank of Captain in 1986.

In 1963, Dr. Byers began his general surgical residency with Dr. Robert Buxton at the University Hospital in Baltimore. Five years later, as a fully trained general surgeon, he went to the Republic of Vietnam with the 1st Marine Division where he received a unit commendation medal and a combat action ribbon. On return to the United States, he spent a year at Quonset Point, Rhode Island Naval Hospital as Chief of Surgery. In 1969, he was certified by the American Board of Surgery. After discharge from the Navy in 1970, Dr. Byers and his family moved to Houston, Texas where he began a fellowship in Surgical Oncology at the University of Texas M.D. Anderson Cancer Center under the guidance of Drs. R. Lee Clark, Richard Martin, Ed White, William MacComb, Richard Jesse and Alando J. Ballantyne. This move proved to be a decisive event, as he never left. His career in Head and Neck Surgical Oncology was born, nurtured, and matured during the 31 years of his academic/clinical practice at the University of Texas M.D. Anderson Cancer Center.

During his tenure at M.D. Anderson Cancer Center he rose through the ranks from Assistant Professor in 1972 to Associate Professor in 1976 and, finally, Professor and Surgeon in 1981.

In 1998, he was honored with the Distinguished Alando J. Ballantyne Chair of Head and Neck Surgery. He is the author or co-author of over 200 published papers, book chapter and monographs. He has given invited lectures all over the world. Most recently (1999), he was selected to give the Hayes Martin Memorial Lecture at the 5th International Conference on Head and Neck Cancer. He has been President of the American Radium Society and President of the Society of Head and Neck Surgeons both in 1995 - 1996. His research interests and his expertise have been focused on cancer of the oral cavity, head and neck cancer in young people and treatment of the neck involved with metastatic cancer with a particular interest in various neck dissections. Dr. Byers is a member of many prestigious societies, of which the Southern Surgical Association, the Texas Surgical Society, the American College of Surgeons and the Society of Surgical Oncologists are but a few. He is a peer reviewer for many medical journals and on the Editorial Board of three. During his 31 years at the University of Texas M.D. Anderson Cancer Center, he has participated in the surgical education of over 300 residents and fellows, many of whom have gone on to become prominent members of the specialty. The youth community of Houston has benefited from his coaching expertise in baseball and basketball while he has indulged in the hobbies of hunting, travel, and collecting toy soldiers.

Alando J. Ballantyne Resident Research Pilot Grant

Alando J. Ballantyne, MD



Alando J. Ballantyne, M.D., a giving teacher, dedicated surgeon, and a devoted husband and father, is memorialized by the Alando J. Ballantyne Resident Research Pilot Grant. This award, in the amount of \$10,000, is awarded for the best grant application by a resident.

Alando, known simply as Jay, grew up in a loving Mormon home that taught him the values of family, excellence, integrity and hard work. Jay graduated Phi Beta Kappa from the University of Arizona and was then awarded a scholarship to Columbia Medical School. During World War II, Jay served as an army captain and medical doctor and had the good fortune to meet his wife, Maria, in San Antonio. In 1947, Dr. Ballantyne became the first resident at the new M.D. Anderson Hospital in Houston. After his year-long residency, he went for further training at the Mayo Clinic in Rochester, Minnesota. He returned to the Anderson staff in 1952, where he quickly advanced from Assistant Surgeon in the Head and Neck Service to Associate Surgeon, and then from 1974 until his retirement in 1994, held the title of Surgeon and Professor of Surgery in the Department of Head and Neck Surgery as well as the title of Ashbel Smith Professor.

Dr. Ballantyne is credited as the first surgeon in the United States to pioneer modified radical neck dissection. His contributions to his subspecialty have been published in numerous scientific papers and book chapters. Jay lectured at local, national, and international forums and loved his travels. He held memberships in many distinguished medical and surgical societies and served as President and Hayes Martin Lecturer of the Society of Head and Neck Surgeons and President of the Texas Surgical Society.

To honor the contributions of this world-renowned surgeon, the Cynthia and George Mitchell Foundation established the Alando J. Ballantyne Distinguished Chair in Head and Neck Surgery at the University of Texas M.D. Anderson Cancer Center.

Dr. Ballantyne's contributions to the subspecialty of Head and Neck cancer surgery have been the result of an undying curiosity and uncanny powers of observation. He was the father of conservative surgery, removing the cancer while preserving the function. He had a relentless desire to eradicate his patients' disease, yet was able to balance this fervor with a desire to maintain quality of life for all his patients.

Always an advocate of reconstruction and preservation of cosmesis as well as function, those fortunate enough to have worked with him and been taught by him are forever indebted to him for his wisdom, surgical expertise, and devotion to his patients. He was beloved by his patients, admired by his peers and idolized by his family.

The Alando J. Ballantyne Resident Research Pilot Grant is funded by the generous contributions of members of the Ballantyne family, including Dr. Gilchrist L. Jackson, a respected member of the American Head and Neck Society.

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WEDNESDAY, APRIL 10, 2013			
Time	Activity	Credits Available	Hours Attended
8:00 AM - 8:15 AM	Welcome and Introduction of Guest of Honor	0	
8:15 AM - 9:15 AM	Panel: Implementation of Quality in Head & Neck Surgery	1	
9:15 AM - 10:00 AM	Hayes Martin Lecture: "Dysphagia: A Silent Killer"	.75	
10:30 AM - 11:30 AM	Scientific Session #1	1	
11:30 AM - 12:30 PM	Panel: Contemporary Management of Oropharynx	1	
1:30 PM - 2:30 PM	Scientific Session #2	1	
2:30 PM - 3:30 PM	Panel: Current Trends in Management NMSC	1	
4:00 PM - 5:00 PM	Scientific Session #3	1	
5:00 PM - 6:00 PM	Panel: Thyroid Controversies In Management & Diagnosis	1	
Total Credits Available for Wednesday, April 10, 2013:		7.75	
THURSDAY, APRIL 11, 2013			
Time	Activity	Credits Available	Hours Attended
8:00 AM - 9:00 AM	Scientific Session #4	1	
9:00 AM - 9:45 AM	John Conley Lecture: "What Would Dr. Conley Think?"	.75	
9:45 AM - 10:00 AM	AHNS Awards Ceremony	0	
10:30 AM - 10:35 AM	Introduction of the AHNS President	0	
10:35 AM - 11:15 AM	AHNS Presidential Address, Distinguished Service Award and Presidential Citations	.5	
11:15 AM - 12:15 PM	Jatin P. Shah Symposium on Clinical Controversies in Head and Neck Surgery: "Controversies in Head & Neck Cancer Management & Reconstruction: Debating the Current Standard of Care"	1	
1:15 PM - 2:15 PM	Scientific Session #5	1	
2:15 PM - 3:15 PM	Panel: Evidence Based Management of Oral Cavity Cancer	1	
3:45 PM - 5:00 PM	Scientific Session #6	1.25	
Total Credits Available for Thursday, April 11, 2013:		6.5	
TOTAL CREDITS AVAILABLE		14.25	

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8:00 - 8:15 AM **Welcome and Introduction of Guest of Honor** Mediterranean 5

**Mark K. Wax, MD, AHNS President and
Eben L. Rosenthal, MD, AHNS Program Chair
Guest of Honor: T. David Briant, MD**

Report From The AHNS Foundation
Randal S. Weber, MD

8:15 - 9:15 AM **Panel: Implementation of Quality in Head & Neck Surgery** Mediterranean 5

**Panel Moderators: M. Boyd Gillespie, MD and
Christine G. Gourin, MD**

This panel will review the current focus on quality improvement as a target for health care reform, and implications for surgeons at the individual, institutional, and policy level. Methods of quality improvement will be discussed using examples from SEER-Medicare data that detect what is done in practice, Cochrane reviews aimed at identifying evidence-based quality measures, institutional data measuring surgeon performance as an indicator of quality, and policy initiatives being implemented by Great Britain's National Health Service (NHS).

8:15 AM **Quality in Head and Neck Surgical Care: Current Practice** Christine G. Gourin, MD

8:27 AM **Evaluating the Evidence** M. Boyd Gillespie, MD

8:39 AM **Evaluating Performance** Randal S. Weber, MD

8:51 AM **Establishing Guidelines: The NHS Example** Nigel J. Beasley, FRCS, MBBS

9:03 AM **Discussion and Questions** All Panelists

At the conclusion of this session, participants will be able to:

- Understand the importance of measuring quality in head and neck surgical practice
- Describe 3 ways that quality can be measured
- Apply quality improvement techniques in practice

The AHNS gratefully acknowledges a generous educational grant in support of this panel from OmniGuide, Inc.

9:15 - 10:00 AM **Hayes Martin Lecture "Dysphagia: A Silent Killer"** Mediterranean 5

**Jonas T. Johnson, MD, Professor and the Eugene N. Myers
Chairman of Otolaryngology, University of Pittsburgh,
Pittsburgh, Pennsylvania**

Introduction by Mark K. Wax, MD

The AHNS gratefully acknowledges educational grants in support of this lecture from our Gold Level supporters, DePuy Synthes, CMF and Stryker.

10:00 - 10:30 AM **Morning Break** Coquina Ballroom

Scientific Program**Wednesday, April 10, 2013**

10:30 - 11:30 AM **Scientific Session #1: Discussion Session** Mediterranean 5

Moderators: Floyd "Chris" Holsinger, MD, Eben L. Rosenthal, MD and David J. Terris, MD

- 10:30 AM **S001: TRANSORAL ROBOTIC SURGERY FOR OROPHARYNGEAL CANCER: LONG TERM QUALITY OF LIFE AND FUNCTIONAL OUTCOMES.** Peter T Dziegielewski, MD, FRCSC, K Durmus, MD, T N Teknos, MD, FACS, M Old, MD, FACS, A Agrawal, MD, FACS, K Kakarala, MD, FACS, E Ozer, MD; The Ohio State University.
- 10:38 AM **COMMENTARY** William M. Lydiatt, MD
- 10:44 AM **COMMENTARY** Bruce H. Haughey, MD
- 10:50 AM **S002: THE IMPACT OF PHARYNGEAL CLOSURE TECHNIQUE ON FISTULA AFTER SALVAGE LARYNGECTOMY.** Urjeet A Patel, MD, Brian Moore, MD, Mark Wax, MD, Eben Rosenthal, MD, Larissa Sweeny, MD, Oleg Militsakh, MD, Joseph A Califano, MD, Alice C Lin, MD, Christine P Hasney, MD, R B Butcher, MD, Jamie Flohr, MD, Demetri Arnaoutakis, MD, Matthew Huddle, MD, Jeremy D Richmon, MD; Northwestern University, Chicago, IL; Oschner Health System, New Orleans, LA; Oregon Health Science University, Portland, OR; University of Alabama, Birmingham, AL; University of Nebraska Medical Center, Omaha, NE; Johns Hopkins Hospital, Baltimore, MD.
- 10:58 AM **COMMENTARY** Matthew M. Hanasono, MD
- 11:04 AM **COMMENTARY** Eric Genden, MD
- 11:10 AM **S003: SO-CALLED TOTAL THYROIDECTOMY: MEASURING THE EXTENT OF THYROID SURGERY WITH RAI.** Juntian Lang, MD, PhD, Uma Ramaswamy, Eric Rohren, MD, Naifa L Bussaidy, MD, Maria E Cabanillas, MD, Randal S Weber, MD, FACS, Christopher F Holsinger, MD, FACS; The University of Texas MD Anderson Cancer Center.
- 11:18 AM **COMMENTARY** Ralph P. Tufano, MD
- 11:24 AM **COMMENTARY** Gregory L. Randolph, MD

11:30 - 12:30 PM **Panel: Contemporary Management Of Oropharynx** Mediterranean 5

Panel Moderator: Robert L. Ferris, MD

A series of short "state of the art" talks on surgical and non-surgical therapy for oropharynx cancer will be presented, followed by real-life decision making by national leaders based on model oropharynx cancer cases for HPV+ and HPV- disease cases.

- 11:30 AM **HPV+: Does adding transoral surgery effectively permit de-escalation and improve functional outcome?** Robert L. Ferris, MD, PhD
- 11:40 AM **HPV- Disease: Can Transoral Surgery Improve Survival?** Floyd "Chris" Holsinger, MD
- 11:50 AM **What is Optimal Nonsurgical Management for Oropharynx Cancer, Induction Chemotherapy or Concurrent Chemoradiation?** Ezra E.W. Cohen, MD
- 12:00 PM **Optimal Reconstruction after Salvage Surgery for Recurrent Oropharynx Cancer?** Eben L. Rosenthal, MD
- 12:10 PM **Cases for Discussion** Andrea "Andy" Trotti, MD

At the conclusion of this session, participants will be able to:

- Describe the role of up-front transoral surgery to reduce the intensity of adjuvant therapy for HPV+ for good prognoses HPV+ disease
- Discuss the likelihood of survival improvement by adding up-front transoral surgery and adjuvant radiation/chemoradiation

- Understand the current prospectively obtained evidence in support of concurrent chemoradiation versus induction chemotherapy
- Be aware of the reconstructive options for recurrent/salvage surgery for recurrent oropharynx cancer

The AHNS gratefully acknowledges educational grants in support of this panel from CelSci Corporation and OmniGuide, Inc.

12:30 - 1:30 PM **AHNS Business Meeting or Lunch on Own** Mediterranean 5

1:30 - 2:30 PM **Scientific Session #2: Reconstruction** Mediterranean 5

Moderators: Oleg Militsakh, MD and Marita S. Teng, MD

1:30 PM **S004: DONOR SITE MORBIDITY IN ELDERLY PATIENTS AFTER FASCIOTOME FREE TISSUE TRANSFER.** Jacob L. Wester, BS, Amy Pittman, MD, Robert H Lindau, MD, Mark K Wax, MD; Oregon Health and Science University.

1:38 PM **S005: USE OF THE SUPRACLAVICULAR ARTERY ISLAND FLAP IN HEAD AND NECK ONCOLOGIC RECONSTRUCTION: APPLICATIONS AND LIMITATIONS.** Niels Kokot, MD, Grace Peng, MD, Kashif Mazhar, MD, Lindsay Reder, MD, Uttam K Sinha, MD; Keck School of Medicine, University of Southern California.

1:46 PM **S006: DISPOSITION OF ELDERLY PATIENTS FOLLOWING HEAD AND NECK MICROVASCULAR RECONSTRUCTION.** Jeanne L. Hatcher, MD, Elizabeth B Bell, BS, Joshua D Waltonen, MD; Wake Forest School of Medicine.

1:54 PM **Discussion (6 minutes)**

2:00 PM **S007: PATHOLOGICALLY DETERMINED TUMOR VOLUME OUTPERFORMS T STAGE IN THE PREDICTION OF OUTCOME FOLLOWING SURGICAL TREATMENT OF OROPHARYNGEAL SQUAMOUS CELL CARCINOMA.** Frank L Palmer, Dr. Nancy Y Lee, Dr. Ian Ganly, Dr. Iain J. Nixon; Memorial Sloan Kettering Cancer Center.

2:08 PM **S008: USE IT OR LOSE IT: SWALLOWING EXERCISE AND MAINTENANCE OF ORAL INTAKE DURING RADIOTHERAPY OF CHEMORADIOTHERAPY FOR OROPHARYNGEAL CANCERS.** Katherine A Hutcheson, PhD, Mihir K Bhayani, MD, Beth M Beadle, MD, PhD, Kathryn A Gold, MD, Eileen H Shinn, PhD, Stephen Y Lai, MD, PhD, Jan S Lewin, PhD; The University of Texas MD Anderson Cancer Center, The University of Chicago Pritzker School of Medicine.

2:16 PM **S009: A COMPARISON OF OUTCOMES USING IMRT AND 3DCRT IN TREATMENT OF OROPHARYNGEAL CANCER.** Shivangi Lohia, BA, Mayuri M Rajapurkar, MD, Anand K Sharma, MD, Terry A Day, MD; Medical University of South Carolina.

2:24 PM **Discussion (6 minutes)**

The AHNS gratefully acknowledges a generous educational grant in support of this session from Stryker.

2:30 - 3:30 PM **Panel: Current Trends in Management NMSC** Mediterranean 5

Panel Moderator: Cecelia Schmalbach, MD, MS

This panel will review current challenges, and provide evidence based literature, for the management of head and neck non-melanoma skin cancer (NMSC). Case based presentations with audience participation will highlight the management of high-risk NMSC, the role of observation, elective neck dissection, and sentinel node biopsy in the N-zero neck, the therapeutic horizons to include adjuvant radiation, chemotherapy and targeted agents and important considerations for successful NMSC reconstruction.

Scientific Program**Wednesday, April 10, 2013**

2:30 PM	Identifying the High-Risk Patient and Managing Their Recurrent Disease	William R. Carroll, MD
2:42 PM	Management of the N-zero in NMSC: Observation, Dissection or Sentinel Node Biopsy	Brian A. Moore, MD
2:54 PM	Adjuvant Treatment & Therapeutic Horizons for NMSC	Michael Kupferman, MD
3:06 PM	Reconstructive Principles Following NMSC Resection	Daniel Alam, MD
3:18 PM	Panel Discussion	All Panelists

At the conclusion of this session, participants will be able to:

- Identify and accurately stage high risk NMSC patients using the current American Joint Committee on Cancer (AJCC) system
- Appropriately utilize sentinel node biopsy, elective neck dissection, and patient observation in the management of N-zero NMSC patients
- Discuss the role of adjuvant treatment to include radiation, chemotherapy, and targeted agents
- Develop a reconstructive algorithm to successfully manage NMSC patients undergoing surgical extirpation

3:30 - 4:00 PM	Afternoon Break	Coquina Ballroom
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4:00 - 5:00 PM	Scientific Session #3: Robotics	Mediterranean 5
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Moderators: Tamer Ghanem, MD, PhD and J. Scott Magnuson, MD

4:00 PM	S010: PROGNOSTIC SIGNIFICANCE OF IMMUNE COMPROMISE AND HISTOLOGIC RISK FACTORS FOR LOCAL CONTROL AND SURVIVAL IN TLM-TRETED ORAL CAVITY SQUAMOUS CELL CARCINOMA. Parul Sinha, MBBS, MS, Mitra Mehrad, MD, Rebecca D Chernock, MD, James S Lewis Jr, MD, Samir K El-Mofty, DMD, PhD, Brian Nussenbaum, MD, <u>Bruce H Haughey, MBChB, FACS, FRACS</u> ; Washington University School of Medicine.
4:08 PM	S011: TRANSORAL ROBOTIC SURGERY (TORS): SIMULATION-BASED STANDARDIZED TRAINING. <u>Ning Zhang</u> , Baran D Sumer, MD; University of Texas Southwestern Medical Center.
4:16 PM	S012: ROBOT-ASSISTED COMPREHENSIVE NECK DISSECTION VIA A TRANSAXILLARY AND RETROAURICULAR ("TARA") APPROACH IN PAPILLARY THYROID CANCER WITH CERVICAL LYMPH NODE METASTASES: A COMPARATIVE STUDY WITH THE TRANSAXILLARY APPROACH. Won Shik Kim, MD, <u>Yoon Woo Koh, MD, PhD</u> , Jae Wook Kim, MD, Hyun Jun Hong, MD, Hyung Kwon Byeon, MD, Young Min Park, MD, Hyo Jin Chung, MD, Sang Chul Park, MD, Michelle J. Suh, MD, Eun Jung Lee, MD, Eun Chang Choi, MD, PhD; 1Department of Otorhinolaryngology, Yonsei University College of Medicine, Seoul, Korea 2Department of Otolaryngology-Head and Neck Surgery, Soonchunhyang University College of Medicine, Seoul, Korea.
4:24 PM	Discussion (6 minutes)
4:30 PM	S013: SURGEON EXPERIENCE AND COMPLICATIONS WITH TRANSORAL ROBOTIC SURGERY (TORS). <u>Stanley H Chia, MD, FACS</u> , Neil D Gross, MD, FACS, Jeremy Richmon, MD, FACS; Medstar Washington Hospital Center, Medstar Georgetown University Hospital, Oregon Health Sciences University, Johns Hopkins Hospital.
4:38 PM	S014: ANALYSIS OF POSTOPERATIVE BLEEDING IN TRANSORAL LASER MICROSURGERY OF THE OROPHARYNX. <u>Taylor R Pollei, MD</u> , Michael L Hinni, MD, Eric J Moore, MD, Richard E Hayden, MD, Logan C Walter, BS, Kerry D Olsen, MD; Mayo Clinic Phoenix, Arizona; Mayo Clinic Rochester, MN.

Scientific Program

Wednesday, April 10, 2013

4:46 PM **S015: SURGICAL FEASIBILITY AND ONCOLOGIC SAFETY OF ROBOT-ASSISTED NECK DISSECTION FOLLOWED BY TRANSORAL ROBOTIC SURGERY (TORS) IN HEAD AND NECK CANCER.** Hyung Kwon Byeon, MD, Jae Wook Kim, MD, Eun Sung Kim, MD, Hyo Jin Chung, MD, Eun Jung Lee, MD, Hyun Jun Hong, MD, Won Shik Kim, MD, Yoon Woo Koh, MD, PhD, Eun Chang Choi, MD, PhD; 1Department of Otorhinolaryngology, Yonsei University College of Medicine, Seoul, Korea 2Department of Otolaryngology-Head and Neck Surgery, Soonchunhyang University College of Medicine, Seoul, Korea.

4:54 PM **Discussion (6 minutes)**

5:00 - 6:00 PM **Panel: Thyroid Controversies in Management & Diagnosis** Mediterranean 5

Panel Moderators: Cherie-Ann O. Nathan, MD and David J. Terris, MD, PhD

This session will discuss the controversies and challenges in the diagnosis and management of thyroidectomy to include the work up of a thyroid nodule focusing on the indeterminate group, determining the extent of surgery for thyroid cancers in this age of personalized medicine with emphasis on ATA guidelines. In addition, controversies in the approach to thyroidectomy and inpatient v/s outpatient stay will be addressed.

5:00 PM **Cervical vs. Extra-Cervical Thyroid Surgery** Jeremy Richmon, MD

5:10 PM **Molecular Diagnostics Can Change the Diagnosis and Management of Thyroid Cancer** Cherie-Ann O. Nathan, MD

5:20 PM **Postoperative Management: Same-Day Surgery vs. Overnight Stay** David J. Terris, MD

5:30 PM **Risk Groups Determine Extent of Treatment for WDTC** Ashok R. Shaha, MD

5:40 PM **Panel Discussion** All Panelists

At the conclusion of this session, participants will be able to:

- Increase awareness of alternative approaches including remote access
- Incorporate the technique of diagnostic molecular panels in the diagnosis and management of well differentiated thyroid cancers
- Properly select patients eligible for outpatient care

6:00 - 6:45 PM **Fellowship Information Session** Mediterranean 5

Jay O. Boyle, MD and William M. Lydiatt, MD

Attend the fellowship information session and learn what fellowships are available and network with program directors.

Scientific Session**Thursday, April 11, 2013****THURSDAY, APRIL 11, 2013**

7:00 - 7:30 AM

NCI-sponsored Clinical Trials in Transoral Endoscopic H&N Surgery: Open Forum and Investigators' Meeting

Mediterranean 5

*This session is not accredited for CME***Robert L. Ferris, MD****Floyd "Chris" Holsinger, MD**

Objectives:

- To review eligibility criteria and primary objectives for HPV+ (ECOG3311) and HPV- (RTOG1221) clinical trials
- To review clinical research infrastructure requirements to participate in NCI-sponsored clinical trials.
- To review requirements for surgeon credentialing and ongoing quality assurance

8:00 - 9:00 AM

Scientific Session #4: Thyroid/General

Mediterranean 5

Moderators: Jeffrey M. Bumpous, MD and Ellie Maghami, MD

8:00 AM

S016: SIGNIFICANT FAMILIAL RISK IN MULTIPLE GENERATIONS OF PAPILLARY THYROID CARCINOMA PROBANDS. Gretchen M Oakley, MD, Karen Curtin, PhD, Luke O Buchmann, MD, Elke Jarboe, MD, Jason P Hunt, MD; University of Utah Health Sciences Center. ***Best Resident Clinical Paper Award Winner**

8:08 AM

S017: MALIGNANCY RATE AND SUBSTRATIFICATION EFFICACY IN THYROID NODULES CLASSIFIED AS ATYPYA OF UNDETERMINED SIGNIFICANCE. Allen S Ho, MD, Evan Sarti, DO, Hangjun Wang, MD, Kunal S Jain, MD, Oscar Lin, MD, Iain J Nixon, MD, Ashok R Shaha, MD, Jatin P Shah, MD, R. Michael Tuttle, MD, Ronald Ghossein, MD, Richard J Wong, MD, Luc G.T. Morris, MD, MSc; Memorial Sloan-Kettering Cancer Center.

8:16 AM

S018: CAUSES OF EMERGENCY ROOM VISITS FOLLOWING THYROID AND PARATHYROID SURGERY. William G Young, MD, Linda Hsu, BS, Eric Succar, BS, Gary Talpos, MD, FACS, Tamer A Ghanem, MD, PhD; Henry Ford Hospital.

8:24 AM

Discussion (6 minutes)

8:30 AM

S019: COMBINED MODALITY TREATMENT OUTCOMES FOR HEAD AND NECK CANCER: COMPARISON OF CARE AT AN ACADEMIC CANCER CENTER VERSUS ACADEMIC-TO-COMMUNITY TRANSFER, 2002-2012. Jonathan R George, MD, MPH, Sue SYom, MD, PhD, Steven J Wang, MD; University of California, San Francisco.

8:38 AM

S020: DESIGNING THE NEXT GENERATION OF BIOREACTORS FOR STEM-CELL TRACHEAL TRANSPLANTATION. Hunter Faircloth, BS, Don Mettenberg, AS, Aaron Cunningham, BS, Matt Jones, MSECE, Madelaine Dubin, Frederick Rueggeberg, DDS, Gregory Postma, MD, Paul Weinberger, MD; Georgia Health Sciences University.

8:46 AM

S021: RISK FACTORS FOR PLACEMENT OF A PERCUTANEOUS ENDOSCOPIC GASTROSTOMY TUBE DURING CHEMORADIOTHERAPY FOR OROPHARYNGEAL SQUAMOUS CELL CARCINOMA. Tobin Strom, MD, Andy Trotti, MD, Nikhil G Rao, MD, Julie A Kish, MD, Judith C McCaffrey, MD, Tapan Padhya, MD, Jimmy J Caudell, MD, PhD; H. Lee Moffitt Cancer Center.

8:54 AM

Discussion (6 minutes)

9:00 - 9:45 AM

John J. Conley Lecture

Mediterranean 5

"What Would Dr. Conley Think?"

Patrick J. Gullane, MD, Wharton Chair Head and Neck Surgery, Professor and Former Chair, Department of Otolaryngology- Head and Neck Surgery, Professor of Surgery, Faculty of Medicine, University of Toronto

Introduction by Mark K. Wax, MD

The AHNS gratefully acknowledges educational grants in support of this lecture from our Platinum Supporters- CelSci Corporation, OmniGuide, Inc. and Pfizer.

9:45 - 10:00 AM

AHNS Awards Ceremony

Mediterranean 5

**Presented by: D. Gregory Farwell, MD and
Wendell G. Yarbrough, MD**

- AHNS Alando J. Ballantyne Resident Research Pilot Grant
- AHNS Pilot Research Grant
- AHNS/AAO-HNS Young Investigator Award, in Memory of Duane A. Sewell, MD
- AHNS/AAO-HNSF Translational Innovator Combined Award
- Robert Maxwell Byers Award
- Best Resident Basic Science Research Paper
- Best Resident Clinical Paper

10:00 - 10:30 AM

Morning Break with Exhibitors

10:00 - 10:35 AM

**Introduction of the
AHNS President**

Mediterranean 5

Introduced by AHNS President-Elect Terry A. Day, MD

10:35 - 11:15 AM

**AHNS Presidential Address,
Distinguished Service Award
and Presidential Citations
*"A New Paradigm in Life Long
Learning: Removing the Silos"***

Mediterranean 5

**Mark K. Wax, MD, Oregon Health and Science University,
Portland, Oregon**

Distinguished Service Award

Dennis H. Kraus, MD

Presidential Citations

Brian B. Burkey, MD

Neal D. Futran, MD, DMD

Paul A. Levine, MD

Jeffrey N. Myers, MD, PhD

Stephen J. Wetmore, MD, MBA

Scientific Session**Thursday, April 11, 2013**11:15 AM - 12:15 PM **Jatin P. Shah Symposium** Mediterranean 5**on Clinical Controversies in Head and Neck Surgery
"Controversies in Head & Neck Cancer Management & Reconstruction:
Debating the Current Standard of Care"****Panel Moderator: Gregory D. Farwell, MD**11:15 AM **Post Therapy Imaging for Tumor Surveillance** Brendan C. Stack, Jr. MD & Mike Yao, MD11:35 AM **Salvage Neck Dissection: Who and When to Operate** Dennis H. Kraus, MD & Kerstin M. Stenson, MD11:55 PM **3D Modeling for Head and Neck Reconstruction** Matthew M. Hanasono, MD & Mark K. Wax, MD

At the conclusion of this session, participants will be able to:

- Identify the role of imaging in the post-treatment management of head and neck cancer patients
- Determine when salvage neck dissection is absolutely necessary and when observation is acceptable
- Describe the role of surgical planning in head and neck cancer reconstruction

12:15 - 1:15 PM **Lunch with Exhibitors** Coquina Ballroom1:15 - 2:15 PM **Scientific Session #5: Salivary/General** Mediterranean 5**Moderators: Nishant Agarwal, MD and Karen T. Pitman, MD**1:15 PM **S022: PROGNOSTIC FACTORS ASSOCIATED WITH DECREASED SURVIVAL IN ACINIC CELL CARCINOMA.** David M Neskey, MD, Jonah D Klein, MS, Adam S Garden, MD, Diana Bell, MD, Adel K El-Naggar, MD, PhD, Merrill S Kies, MD, Randall S Weber, MD, Michael E Kupferman, MD; UT MD Anderson Cancer Center.1:23 PM **S023: RACIAL AND ETHNIC DISPARITIES IN SALIVARY GLAND CANCER SURVIVAL.** Shani J Ortiz, BS, Vicente A Resto, MD, PhD, Travis P Schrank, MD, PhD; The University of Texas Medical Branch.1:31 PM **S024: MANAGEMENT OF THE NECK IN CARCINOMA OF THE PAROTID GLAND.** Safina Ali, MD, Frank L Palmer, BA, Monica Whitcher, BA, Jatin P Shah, MD, Snehal G Patel, MD, Ian Ganly, MD, PhD; Memorial Sloan-Kettering Cancer Center.1:39 PM **Discussion (6 minutes)**1:45 PM **S025: PROGNOSTIC FACTORS OF LOCALIZED SINONASAL MUCOSAL MELANOMA.** Adil Benlyazid, MD, Thomas Filleron, PhD; Institut Claudius Regaud.1:53 PM **S026: SUPRACRICOID PARTIAL LARYNGECTOMY FOR PRIMARY AND RECURRENT LARYNGEAL CANCER.** Steven M Sperry, MD, Christopher H Rassekh, MD, Gregory S Weinstein, MD; University of Pennsylvania. ***Robert Maxwell Byers Award Winner**2:01 PM **S027: IMPACT OF SURGICAL RESECTION ON SURVIVAL IN PATIENTS WITH ADVANCED REGIONAL METASTATIC HEAD AND NECK CANCER INVOLVING CAROTID ARTERY.** Nauman Manzoor, MD, Jonathon Russell, MD, Shlomo Koyfman, MD, Joseph Scharpf, MD, Brian Burkey, MD, Mumtaz Khan, MD; Head and Neck Institute / Cleveland Clinic Foundation, Cleveland, Ohio, USA.2:09 PM **Discussion (6 minutes)**

2:15 - 3:15 PM **Panel: Evidence Based Management of Oral Cavity Cancer** Mediterranean 5

Panel Moderators: Brian Nussenbaum, MD and Hadi Seikaly, MD, FRCS

This panel will review and discuss current practices in the management of oral cavity carcinoma. Using evidence based medicine and data to support the expert opinions, the current role surgery (including considerations of biomarkers), role of chemoradiation as definitive or adjuvant therapy, and the role of reconstruction (particularly focusing on glossectomy and lateral mandibulectomy defects) in the treatment of oral cavity carcinoma will be highlighted.

2:15 PM **Evidence for Surgery: Will Management Decisions Change with the Use of Biomarkers in 2013** Eduardo Mendez, MD

2:30 PM **Evidence for Definitive or Adjunctive Use of Chemoradiation: Standard Therapy in 2013** Kerstin M. Stenson, MD

2:45 PM **Evidence for Reconstruction: Reporting Functional Outcomes in 2013** Eric Genden, MD

3:00 PM **Panel Discussion** All Panelists

At the conclusion of this session, participants will be able to:

- Describe NCCN guidelines for management of oral cavity cancer
- Discuss evidence based principles for the appropriate use of surgery, radiation, and chemoradiation in the management of oral cavity patients, and how to incorporate these therapies in the most effective manner
- Understand how to make treatment decisions regarding reconstruction of oral cavity defects, with the abundance of expert opinion and lack of comparative effectiveness studies
- Recognize the emerging role of using biomarkers in this patient population and how these biomarkers may be incorporated into future evidence based medicine treatment guidelines

The AHNS acknowledges a generous educational grant in support of this panel from CelSci Corporation.

3:15 - 3:45 PM **Afternoon Break** Coquina Ballroom

3:45 - 4:45 PM **Scientific Session #6: Basic Science** Mediterranean 5

Moderators: Eduardo Mendez, MD and Wendell G. Yarbrough, MD

3:45 PM **S028: FOLATE RECEPTOR BETA TARGETING FOR INVIVO OPTICAL IMAGING OF HEAD AND NECK SQAMOUIIS CELL CARCINOMA.** Joel Y Sun, Joel Thibodeaux, Gang Huang, Yiguang Wang, Jingming Gao, Philip S Low, Baran D Sumer; University of Texas Southwestern Medical Center; Purdue University.

3:53 PM **S029: DECITABINE AND CISPLATIN COMBINATION THERAPY FOR HEAD AND NECK SQUAMOUIIS CELL CARCINOMA.** Chi T Viet, DDS, PhD, Dongmin Dang, MD, YiYe, PhD, Brian L Schmidt, DDS, MD, PhD; New York University, Bluestone Center for Clinical Research.

***Best Resident Basic Science Paper Award Winner**

4:01 PM **S030: USE OF RETINOBLASTOMA PROTEIN (PRB) IMMUNOHISTOCHEMICAL STAINING AS A PROGNOSTIC INDICATOR IN OROPHARYNGEAL SQUAMOUIIS CELL CARCINOMA.** Adam L Baker, MD, Joseph Curry, MD, Gao W, BS, Cognetti D, MD, T Zhan, PhD, V Bar-Ad, MD, MTuluc, MD; Thomas Jefferson University, Departments of Otolaryngology, Radiation Oncology, and Pathology.

Scientific Session**Thursday, April 11, 2013**

- 4:09 PM **Discussion (6 minutes)**
- 4:15 PM **S031: ROLE OF HPV DNA DETECTION IN PLASMA AND SALIVA IN THE EARLY DETECTION AND PREDICTION OF RECURRENCE IN HPV POSITIVE OROPHARYNGEAL CARCINOMA.** Sun M Ahn, MD, Jason Y Chan, MBBS, Daria Gaykalova, PhD, Joseph A Califano, MD; Department of Otolaryngology, Head and Neck Surgery, Johns Hopkins Medical Institutions & Milton J Dance Head and Neck Center, Greater Baltimore Medical Center, Baltimore, Maryland.
- 4:23 PM **S032: PREVENTION OF DEPRESSION USING ESCITALOPRAM IN PATIENTS UNDERGOING TREATMENT FOR HEAD AND NECK CANCER.** William Lydiatt, MD, Diane Bessette, PA, Kendra Schmid, PhD, Harlan Dayles, MS, William Burke, MD; Nebraska Medical Center and Nebraska Methodist Hospital.
- 4:31 PM **S033: SIGNIFICANCE OF PIK3CA MUTATIONS IN OROPHARYNGEAL SQUAMOUS CELL CARCINOMA.** Andrew B Sewell, MD, Natalia Isaeva, PhD, Wendell G Yarbrough, MD, MMHC, FACS; Yale University, Vanderbilt University.
- 4:39 PM **Discussion (6 minutes)**

Meeting Adjourns

4:45 - 5:30 PM **Centurion Club Reception** Amarante 1

5:30 - 7:00 PM **President's Poster Discussion Session** Coquina Ballroom

**Poster Tour Moderators: Tamer Ghanem, MD
Kelly M. Malloy, MD
Susan D. McCammon, MD
Jason G. Newman, MD**

The AHNS gratefully acknowledges educational grant support from our Silver Level Supporter - Medtronic Surgical Technologies.

7:15 - 8:30 PM **AHNS President's Reception** Mediterranean 6-8

Please join Dr. and Mrs. Mark Wax for an evening reception with the AHNS President.

All registered AHNS attendees and guests are welcome.

The AHNS acknowledges the following companies in support of the President's Reception:

CelSci Corporation

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Faculty Listing

- Nishant Agarwal, MD** – Baltimore, MD
Daniel Alam, MD – Cleveland, OH
Nigel J. Beasley, FRCS, MBBS – Nottingham, England
Jay O. Boyle, MD – New York, NY
Jeffrey M. Bumpous, MD – Louisville, KY
William R. Carroll, MD – Birmingham, AL
Ezra E.W. Cohen, MD – Chicago, IL
Terry A. Day, MD – Charleston, SC
Gregory D. Farwell, MD – Sacramento, CA
Robert L. Ferris, MD, PhD – Pittsburgh, PA
Eric Genden, MD – New York, NY
Tamer Ghanem, MD, PhD – Detroit, MI
M. Boyd Gillespie, MD – Charleston, SC
Christine G. Gourin, MD – Baltimore, MD
Patrick J. Gullane, MD – Toronto, ON, Canada
Matthew M. Hanasono, MD – Houston, TX
Floyd “Chris” Holsinger, MD – Houston, TX
Jonas T. Johnson, MD – Pittsburgh, PA
Dennis H. Kraus, MD – New York, NY
Michael Kupferman, MD – Houston, TX
William M. Lydiatt, MD – Omaha, NE
Ellie Maghami, MD – Duarte, CA
J. Scott Magnuson, MD – Birmingham, AL
Eduardo Mendez, MD – Seattle, WA
Oleg Militsakh, MD – Omaha, NE
Brian A. Moore, MD – New Orleans, LA
Cherie-Ann O. Nathan, MD – Shreveport, LA
Brian Nussenbaum, MD – St. Louis, MO
Karen T. Pitman, MD – Gilbert, AZ
Jeremy Richmon, MD – Baltimore, MD
Eben L. Rosenthal, MD – Birmingham, AL
Cecelia Schmalbach, MD, MS – Lackland AFB, TX
Hadi Seikaly, MD – Edmonton, AB, Canada
Ashok R. Shaha, MD – New York, NY
Brendan C. Stack, Jr., MD – Little Rock, AR
Kerstin M. Stenson, MD – Chicago, IL
Marita S. Teng, MD – New York, NY
David J. Terris, MD – Augusta, GA
Andrea (Andy) Trotti, MD – Tampa, FL
Mark K. Wax, MD – Portland, OR
Randal S. Weber, MD – Houston, TX
Mike Yao, MD – Scarsdale, NY
Wendell G. Yarbrough, MD – New Haven, CT

Faculty, Presenter & Planning Committee Disclosures

The following faculty & presenters provided information indicating they have a financial relationship with a proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies. (Financial relationships can include such things as grants or research support, employee, consultant, major stockholder, member of speaker's bureau, etc.)

Name	Commercial Interest	What Was Received	For What Role
M. Boyd Gillespie, MD*	Medtronic	Consulting Fee	Independent Contractor
	Olympus	Consulting Fee	Consultant
Neal Dwayne Gross, MD*	Bristol Myers Squibb	Honoraria	Speaker
	Intuitive Surgical	Honoraria	Surgical Proctor
Dennis H. Kraus, MD	Endoethicon	Honoraria	Speaker/Teaching
Eduardo Mendez, MD*	Intuitive Surgical, Inc.	Honoraria	Speaking/Teaching
Jason G. Newman, MD*	Intuitive Surgical, Inc.	Payment/Fee	Proctoring
Jeremy Richmon, MD*	Intuitive Surgical, Inc.	Consulting Fee	Consultant
Brendan C. Stack, Jr., MD	Novartis/Hollingsworth LLP	Consulting Fee	Consultant
David J. Terris, MD	Johnson and Johnson	Honoraria	Speaking/Teaching

The following faculty, presenters and program committee members do not have any relevant financial relationships or significant commercial interests associated with their participation at the AHNS 2013 Annual Meeting.

Amit Agarwal, MD*	Christine G. Gourin, MD	Vicente Resto, MD, PhD*
Nishant Agarwal, MD	Patrick J. Gullane, MD	James Rocco, MD, PhD*
Daniel Alam, MD	Patrick K. Ha, MD*	Cecelia Schmalbach, MD, MS
Stephen W. Bayles, MD*	Matthew M. Hanasono, MD*	Hadi Seikaly, MD*
Nigel J. Beasley, FRCS, MBBS	Michael L. Hinni, MD*	Ashok R. Shaha, MD
Brendon G. Bentz, MD*	Floyd "Chris" Holsinger, MD	Yelizaveta Lisa Shnyder, MD*
Jay O. Boyle, MD	Joshua Hornig, MD	Uttam K. Sinha, MD*
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Brian B. Burke, MD*	Michael Kupferman, MD	Marita S. Teng, MD*
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Thomas Gal, MD, MPH*	Brian Nussenbaum, MD*	
Eric Genden, MD	Karen T. Pitman, MD	
Tamer Ghanem, MD, PhD*	Eben L. Rosenthal, MD	

Oral Papers

S001: TRANSORAL ROBOTIC SURGERY FOR OROPHARYNGEAL CANCER: LONGTERM QUALITY OF LIFE AND FUNCTIONAL OUTCOMES

Peter T Dziegielewski, MD, FRCS, K Durmus, MD, T N Teknos, MD, FACS, M Old, MD, FACS, A Agrawal, MD, FACS, K Kakarala, MD, FACS, E Ozer, MD; The Ohio State University

Objective: To determine swallowing, speech and quality of life (QOL) outcomes following transoral robotic surgery for oropharyngeal squamous cell carcinoma (OPSCC).

Design: Prospective cohort study

Setting: Tertiary care academic comprehensive cancer center

Patients: 80 consecutive patients with previously untreated OPSCC

Intervention: Primary surgical resection via trans-oral robotic surgery (TORS) and neck dissection as indicated.

Main Outcome Measures: Patients were asked to complete the Head and Neck Cancer Inventory (HNCI) pre-operatively and at 3 weeks as well as 3, 6 and 12 months post-operatively. Swallowing ability was assessed by independence from a gastrostomy Tube (G-Tube) at the same time points. Demographic, pathological and follow-up data were also collected. Factors predictive of a lower quality of life were identified with a multivariate analysis.

Results: The median follow-up time was 18.3 months. The HNCI response rates at 3 weeks and 3, 6, and 12 months were 80%, 80%, 63%, 54% respectively. There were overall declines in eating, aesthetic, social and overall QOL domains in the early post-operative periods. However, at 1 year after TORS scores for aesthetic, social and overall QOL remained high. Speech scores remained high throughout time periods. T-classification, N-Classification, age and post-operative radiation/chemotherapy correlated with lower QOL ($p < 0.05$). HPV status did not correlate with any QOL domain. The G-Tube rates at 3 weeks and 3 months, 6 months and 1 year were 10%, 20%, 5%, and 2.5% respectively. T-classification and post-operative adjuvant treatment correlated with the need for a G-Tube at 1 year after surgery ($p < 0.05$).

Conclusions: Patients with OPSCC treated with TORS maintain a high QOL at 1 year after surgery. Those with advanced disease or receiving adjuvant treatment can expect a decline in QOL.

S002: THE IMPACT OF PHARYNGEAL CLOSURE TECHNIQUE ON FISTULA AFTER SALVAGE LARYNGECTOMY

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Background: Fistula following laryngectomy

occurs much more frequently in the salvage setting and tends to be of greater duration and severity than after primary laryngectomy. A number of strategies have been attempted to reduce the incidence of fistula in this patient population. Various institutions utilize non-radiated, vascularized flaps in either an interposed or onlay fashion to reconstruct or reinforce the pharyngotomy closure. Studies to date are inconclusive regarding the success of this strategy over simple primary closure.

Objective: To determine if use of vascularized tissue reduces the incidence or severity of pharyngocutaneous fistula after salvage laryngectomy

Design: Multi-institutional retrospective review

Setting: Academic, tertiary referral centers

Patients: All patients with history of laryngeal irradiation undergoing salvage laryngectomy between 1/2005 and 1/2012, with inclusion irrespective of closure type. Patients with extended laryngectomies, pharyngotomy defects that could not be closed primarily, or who received post-operative radiation were excluded. Closure type was grouped as primary, pectoralis myofascial flaps that were onlayed over the closed pharyngotomy, and free tissue that was interposed into the pharyngeal defect.

Main Outcome Measures: Impact of closure type on fistula incidence and severity, other predictors of fistula

Results: The study included 350 patients from 7 institutions. Pharyngocutaneous fistula occurred in 94 patients (27%). For those patients that developed fistula, hospital stay increased from 8.9 to 12.1 days ($p < .0001$) and initiation of oral diet was delayed to 29.9 days from 10.5 days ($p < .00001$). Patients were grouped according to closure type: primary closure ($n = 99$), pectoralis onlay flap ($n = 40$), and interposed free tissue ($n = 220$). The incidence of fistula for patients closed primarily was 34%. When non-radiated, vascularized tissue was used, there was a notable reduction in fistula rate. The incidence of fistula in the pectoralis onlay group was 15% ($p = .019$) and was 24.6% ($p = .07$) for the group closed with interposed free tissue. Multivariate analysis revealed the only independent predictors of fistula were age and closure technique, with both pectoralis myofascial onlay flap and interposed fasciocutaneous free flap associated with lower rate of fistula. Other variables such as albumin, hemoglobin, use of chemotherapy, and presence of comorbidity were not significantly associated with fistula in this study. For the 94 patients that developed fistula, the mean duration of fistula was significantly longer for the primary closure group (18.8 weeks) compared to the pectoralis flap group (9.0 weeks) and the free flap group (6.5 weeks).

Conclusions: Pharyngocutaneous fistula remains a significant problem following salvage laryngectomy, resulting in prolonged hospital stay and delayed initiation of oral diet. Use of non-radiated, vascularized tissue reduced incidence of fistula in this population. When fistula did occur, the duration was

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significantly shorter for patients initially closed with either flap technique compared to primary closure. Onlay or interposed flap closure to reduce incidence and severity of fistula should be considered when performing salvage laryngectomy.

S003: SO-CALLED TOTAL THYROIDECTOMY: MEASURING THE EXTENT OF THYROID SURGERY WITH RAI

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Objective: To investigate the rate of patients with or without thyroid remnant and the relationship between postoperative stimulated thyroglobulin(Tg) level and thyroid remnants after total thyroidectomy for patients with differentiated thyroid carcinoma.

Patients and Methods: We evaluated patients undergoing total thyroidectomy at MD Anderson Cancer Center from 01/01/2001 to 02/20/2012 for T1-3N0M0 differentiated thyroid cancer (DTC) who received diagnostic post-operative radioactive iodine imaging. Two hundred and twenty-nine patients had quantitated uptake on RAI imaging and were included in this study. Based on the calculation of 1123 background signal, radioactive iodine uptake of 0.2% was taken as the cut-off of presence or absence of thyroid remnant. Average time to last follow-up was 45.2 months.

Results: Ninety-three patients (40.6%) with uptake of radioactive iodine less than 0.2% on post-operative imaging suggesting that a total thyroidectomy was performed. The remaining 136 patients demonstrated some measurable iodine-avid thyroid tissue and/or tumor in the thyroid bed (112; 82.4%), the neck (6; 4.4%) or both (17, 12.5%). For those patients with positive iodine signal, the average 24-hour iodine uptake was 1.1% (0.2-7.0%). For the entire study population (229 pts), average 24-hour iodine uptake was 0.67%. Measurable Tg ($\geq 1\text{ng/ml}$) was found in 19/93 (20.4%) patients without thyroid remnant and in 82/136 (60.3%) ($\chi^2=38.5$, $p=0.000$) with thyroid remnant. There were five recurrences (2%), three of which were RAIU positive, and two patients showed no postoperative thyroid remnant. One patient with RAI proven thyroid remnant died of disease.

Conclusion: One hundred and thirty-six of 229 (59.4%) DTC patients had residual thyroid tissue after total thyroidectomy. The rate of detectable Tg in thyroid remnant positive group is higher than that of thyroid remnant negative group (60.3% vs. 20.4%, $p=0.000$).

S004: DONOR SITE MORBIDITY IN ELDERLY PATIENTS AFTER FASCIOTOMY FREE TISSUE TRANSFER

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Objectives: Several studies have shown excellent reconstructive outcomes using free tissue transfer in elderly patients. These studies, however, are limited in size and few

describe long term donor site morbidity. The purpose of our study is to assess donor site morbidity after fasciocutaneous free tissue transfer in patients 70 years and older.

Methods: Patients were identified from 2002-2011 at a tertiary-care center who were over 70 years of age and had fasciocutaneous free flap reconstruction of the head and neck. Donor sites included; radial forearm (RFFF), ulnar forearm (UFFF) and anterolateral thigh (ALT). 171 younger patients from the same time period were randomly selected to act as controls. Demographic, surgical and clinical data were extracted from the electronic medical record. Donor site morbidity was compared between the two groups.

Results: 622 fasciocutaneous free flaps were performed during the study period. 158 (25.4%) flaps were performed on patients 70 years and older, with a median age of 77 years (70-92). There were 100 RFFF, 9 UFFF, and 49 ALT flaps performed. The median paddle size was 64 cm² and median follow up time was 10 months. Overall donor site morbidity in patients 70 years and older was 22.2% vs. 25.2% in patients less than 70 years, $p=0.6$. Infection was the most common morbidity in the elderly (8.9%) and was not significantly different from younger patients (9.4%), $p=0.84$. Complete loss of STSG (6.2% vs. 2.9%, $p=0.34$), forearm tendon exposure (7.1% vs. 3.9%, $p=0.38$), extremity numbness (4.7% vs. 3.2%, $p=0.57$) and seroma (5.2% vs. 2.5%, $p=0.26$) were not significantly different.

Conclusion: Donor site morbidity may be expected in up to 1 of 4 patients after fasciocutaneous free tissue transfer. Age over 70 years does not increase this risk.

S005: USE OF THE SUPRACLAVICULAR ARTERY ISLAND FLAP IN HEAD AND NECK ONCOLOGIC RECONSTRUCTION: APPLICATIONS AND LIMITATIONS

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Objective: Free tissue transfer has become the standard of care for head and neck reconstruction in academic medical centers. The radial forearm free flap (RFFF) and anterolateral thigh (ALT) free flap are two workhorse flaps for soft tissue reconstruction. The supraclavicular artery island (SAI) flap is a local rotational flap that has been described as an alternative to free tissue transfer in head and neck reconstruction. We previously presented our initial experience using the SAI flap. The purpose of this study is to present our currently larger experience using the SAI flap, including some of its limitations.

Methods: Retrospective chart review of our first 45 consecutive patients who underwent reconstruction with SAI flap following head and neck oncologic surgery was done, after obtaining IRB approval. Information on prior treatment, size and location of defect, time required to raise the flap, time to de-epithelialize the flap, flap viability, donor site morbidity, and complications was collected. All statistical analysis was done using SAS 9.1.

Results: 38 out of 45 patients underwent ablative surgery for head and neck carcinoma

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and had a SAI flap performed as their soft tissue reconstruction, while 7 patients had a SAI flap for reconstruction of a non-cancer related defect. Defects of the oral cavity (n=13), oropharynx (n=7), laryngopharynx (n=8), esophagus (n=1), trachea (n=1), temporal bone (n=5), and cervical skin (n=10) were reconstructed. Mean flap width was 6.1cm (range 5-9cm), allowing for primary closure in all cases. Mean flap length was 21.4cm (range 15-28cm), with the proximal portion of the flap de-epithelialized to match the defect resulting in a mean skin paddle length of 7.91 cm (range 5-15cm). Mean harvest time was 34.9 minutes (range 17-60 min), and mean time for de-epithelialization was 15.2 minutes (range 5-40 min). Minor donor site dehiscence occurred in 6 patients (13.6%), while dehiscence requiring prolonged wound care occurred in 2 patients (4.5%). No patients reported severe limitations of arm movement. Partial skin flap necrosis occurred in 8 (17%) patients, while 2 (4%) patients had complete loss of the skin paddle. Salivary fistula developed in 7 (15.5%) patients, 4 of which healed spontaneously. A second reconstructive procedure using an alternate flap was required in 4 patients (9.1%). There were 6 patients (13.6%) with neck related complications. There was a significant correlation between flap length greater than 22 cm and flap necrosis (chi-sq p=0.01). No significant correlation between flap location or flap necrosis and fistula was found.

Conclusions: The SAI flap is a viable alternative to microvascular reconstruction of head and neck defect in select cases. This flap is fairly reliable, easy to harvest, and versatile. However, after initial success using this flap, we have determined that the SAI flap has limitation in length, with flaps longer than 22cm having a higher incidence of necrosis. Because it is a rotational flap, it is also limited in reconstructing some complex head and neck defects. As a result, we have become more selective in its application.

S006: DISPOSITION OF ELDERLY PATIENTS FOLLOWING HEAD AND NECK MICROVASCULAR RECONSTRUCTION

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INTRODUCTION: With the US population aging, more elderly patients are being diagnosed with head and neck cancers. Comorbidities are more common in elderly patients, and there are concerns about the morbidity of lengthy surgery, such as with microvascular head and neck reconstruction, and its impact on the elderly patient. The post-hospitalization needs and disposition of this patient population, for example discharge to home versus a skilled nursing facility, has not been studied. The purpose of this study is to investigate whether or not the elderly, as compared to younger patients, are more likely to be discharged to a nursing or other care facility as opposed to returning home following microvascular reconstruction of the head and neck.

METHODS: The medical records of 450 patients undergoing head and neck microvascular reconstruction were reviewed. The patients' age at the time of procedure,

primary diagnosis, site of tumor involvement, revision versus primary procedure, American Society of Anesthesiologists (ASA) score, length of postoperative stay, and disposition following hospitalization were analyzed. Associations between variables were analyzed using the paired t, chi-square, Fisher exact, and Kruskal-Wallis tests to determine odds ratios (OR) on a multinomial regression model.

RESULTS: The average age of participants was 59.1; 278 of the 450 were under the age of 65. The median length of stay was 10 days. Most patients were discharged home with or without home health services, n = 386 (85.8%). Of those discharged home, 267 (69.2%) were under 65 years old, the remaining 65 and over (p < 0.0001). The average age of those discharged home was 57.5; discharge to home was the reference for comparison and odds ratio (OR) calculation. For those discharged to a skilled nursing facility (SNF), average age was 67.1 (OR 5.5, p=0.0005). Average age of those discharged to a long-term acute care (LTAC) facility was 71.5 (OR 9.2, p=0.0024). With each year older a patient is, the odds of going to a nursing facility are 5.5% higher than going home. When controlling for the ASA score, the OR were even higher and remained significant for discharge to SNF and LTAC. Length of stay also impacted the disposition. The average LOS for those under 65 was 12.4 (3-75, SD=9.3), 65 and over 16.7 (3-80, SD=13.6). Primary versus salvage procedures as well as the number of tumor sites involved did not affect the disposition with statistical significance.

CONCLUSIONS: Previous research has shown that the elderly patient is just as likely to survive a major surgical procedure such as head and neck reconstruction as one under age 65. However this study demonstrates that older patients are less likely to be discharged home at the end of the hospitalization. Age, independent of comorbidities as measured by the ASA score, as well as the length of stay are risk factors for discharge to a nursing or other care facility as opposed to home following microvascular reconstruction.

S007: PATHOLOGICALLY DETERMINED TUMOR VOLUME OUTPERFORMS STAGE IN THE PREDICTION OF OUTCOME FOLLOWING SURGICAL TREATMENT OF OROPHARYNGEAL SQUAMOUS CELL CARCINOMA

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Introduction: Traditional prognostic models for squamous cell carcinoma (SCC) of the head and neck are based on the TNM staging system. However, there is growing evidence that tumor volume (TV) may be a more accurate predictor of outcome. The majority of groups who have investigated the impact of TV used radiological estimates prior to radiation therapy rather than pathologically measured dimensions determined following surgery. The aim of our study was to determine if pathological TV, in patients treated surgically with oropharyngeal SCC, is prognostic of outcome, and how it compares in prognostic value to pathological T stage.

Patients and Methods: 159 consecutive patients who had primary surgical resection

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of oropharyngeal SCC, and had 3 dimensions reported on histopathology within Memorial Sloan Kettering Cancer Center between 1985-2005 were identified. The pathological TV was calculated as the product of the 3 dimensions expressed in cubic centimeters. Disease specific mortality (DSM) local recurrence (LR), regional recurrence (RR) and distant recurrence (DR) were calculated using the Kaplan Meier method for all investigated outcomes except the disease specific death that was estimated by cumulative incidence functions after treating death from causes as competing risks. The relationship between pT stage and outcomes was evaluated using the log rank test or the non-parametric Gray test for disease specific death. The relationship between pTV and outcome was based on the univariable analysis by treating the volume as a continuous predictor with splines to accommodate non-linear relation without categorization. For comparison of pT stage with pTV in outcome prediction, concordance indices were generated using the bootstrap method (n=1000) to quantify the predictive accuracy. Concordance indices were then compared and a significant difference was considered when p<0.05.

Results: The median age was 59 years (range 22-84). There were 106 men (67%) and 53 women (33%). 86 patients had base of tongue (54%), 48 tonsil (30%), 24 soft palate (15%) and 1 posterior pharyngeal wall (1%) tumors. The median follow up was 64 months (range 1-272 months). The median tumor volume was 6.8 cm3 (range 0.045-163 cm3).

The 5 year disease specific mortality (DSM), local recurrence (LR), regional recurrence (RR) and distant recurrence free survival (DR) were 23%, 16%, 13% and 17% respectively.

pT stage, was a significant predictor of 5 year DSM, with pT1 5y DSM of 6%, pT2 12%, pT3 25% and pT4 46%, p<0.001. However, pT stage was not a significant predictor of LR, RR or DR. univariate analysis of outcome, tumor volume was a significant predictor of DSM. However, unlike pT, pTV was a significant predictor of LR, RR and DR (Table 1). Comparison of concordance indices showed that pathological TV was a significantly better predictor of DSM, LR and DR (p<0.05) (Figure 1).

Conclusion: Pathological tumor volume outperforms pT stage in the prediction of outcome following surgical treatment of oropharyngeal cancer.

S008: USE IT OR LOSE IT: SWALLOWING EXERCISE AND MAINTENANCE OF ORAL INTAKE DURING RADIOTHERAPY OR CHEMORADIOTHERAPY FOR OROPHARYNGEAL CANCERS

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BACKGROUND: Data support proactive swallowing therapy during radiotherapy (RT) or chemoradiotherapy (CRT). The benefits of both swallowing exercise and maintenance of oral intake throughout treatment are reported, but independent effects are unclear.

METHODS: We conducted a retrospective study of patients treated with definitive RT or CRT for oropharyngeal cancer (2003-2008). Exclusion criteria were palliative RT, postoperative RT, dose <66Gy, or incomplete response at the primary site. Primary outcomes were length of gastrostomy-dependence and diet level ≥12-months after RT/CRT. Primary independent variables included per oral (PO) status at the end of RT/CRT (nothing per oral [NPO], partial PO, complete PO) and swallowing exercise adherence per medical records. Multiple linear regression and ordered logistic regression models were analyzed.

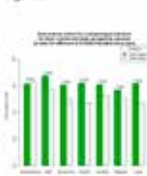
RESULTS: Four hundred fifty-eight patients were included. At the conclusion of RT/CRT, 119 (26%) were NPO, 151 (33%) were partially PO, and 185 (40%) were completely PO. Fifty-seven percent (259/458) reported adherence to swallowing exercises. Maintenance of PO intake during RT/CRT and swallowing exercise adherence were independently associated (p<0.05) with higher diet levels ≥12-months after RT/CRT and shorter length of gastrostomy dependence in models adjusted for tumor stage and concurrent chemotherapy. The proportion of patients returning to a regular diet ≥12-months after RT was: 67% of those who were NPO during RT and did not perform exercises, 83% who either performed swallowing exercises or maintained some PO throughout RT, and 91% who were both adherent and maintained complete PO during RT/CRT (p=0.001). Among 285 patients who received a PEG, median PEG dependence was 219 days among those who were NPO and did not perform exercises, 141-153 days among those who either maintained some PO throughout RT/CRT or performed swallowing exercises, and 101 days among those who both maintained some PO and performed swallowing exercises (p=0.043).

CONCLUSIONS: Data indicate an independent association between swallowing exercise adherence and maintenance of PO intake throughout RT/CRT with long-term swallowing outcomes. Patients who either eat or exercise fare better than those who do neither. Patients who both eat and exercise have the highest return to a regular diet and least gastrostomy dependence.

Table 1. Univariate Analysis of Pathological Tumor Volume as a Predictor of Outcome

	Univariate analysis P
Overall	0.001
DSM	0.001
LR	0.001
RR	0.001
DR	0.001
Region	0.001
Stage	0.001

Figure 1.



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S009: A COMPARISON OF OUTCOMES USING IMRT AND 3DCRT IN TREATMENT OF OROPHARYNGEAL CANCER

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Background: Head and neck squamous cell carcinoma (SCC) represents approximately 6% of all newly diagnosed cancers in the United States with the majority of patients receiving radiation during the course of their treatment either combined with chemotherapy or following surgery. While innovations in therapy have improved long-term survival rates, treatment related toxicities and side effects from radiation therapy remain high. Approximately 50% of all head and neck cancer survivors suffer from dysphagia and dysphagia-related morbidity. Thus, intensity modulated radiation therapy is being increasingly used in the treatment of oropharyngeal cancers for definitive treatment with excellent oncologic outcomes. However, there are few studies comparing outcomes between IMRT and conventional radiation therapy (CRT).

Methods: We performed a retrospective review of patients who underwent either IMRT or 3D-CRT for definitive treatment of oropharyngeal squamous cell carcinoma at MUSC. Primary endpoints included: gastrostomy (PEG) tube dependence 1 year after radiation start, time to PEG tube removal, weight loss during treatment, disease-free survival, and toxicity profiles at treatment completion.

Results: Of 315 patients identified in the Head and Neck database, 159 had oropharyngeal primaries and underwent definitive radiation therapy. Fifty-six patients were treated with 3D-CRT, and 103 with IMRT. Patients treated with IMRT had significantly lower rates of PEG tube dependence one year after treatment initiation regardless of dose ($p=0.0223$) or T-stage ($p=0.012$), and a shorter time to PEG tube removal ($p<0.001$). Acute grade ≥ 3 skin and mucous membrane toxicity occurred less frequently in the IMRT group ($p=0.0213$ and $p<0.0001$ respectively). There were no significant differences in weight loss, treatment failure (hazard ratio=0.82; 95% CI: 0.47 to 1.41), overall survival ($p=0.446$), or disease free survival ($p=0.262$) between the two groups.

Conclusion: The use of IMRT techniques significantly improves PEG tube and toxicity related outcomes compared to conventional radiation therapy in the treatment of primary cancers of the oropharynx. Given the association between mucosal toxicity, PEG tube dependence, and dysphagia these findings may be an indication of improved swallowing outcomes with the use of IMRT.

S010: PROGNOSTIC SIGNIFICANCE OF IMMUNE COMPROMISE AND HISTOLOGIC RISK FACTORS FOR LOCAL CONTROL AND SURVIVAL IN TLM-TREATED ORAL CAVITY SQUAMOUS CELL CARCINOMA

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Background: Oral cavity squamous cell carcinoma (OCSCC) remains an aggressive disease with substantial mortality. Local recurrences portend a bad outcome despite the excellent surgical margin control achieved with transoral laser microsurgery (TLM). Appreciable local recurrence (LR) rates observed in margin-negative, TLM-treated, OCSCC patients necessitate investigation of new reliable prognosticators for local control. Systemic factors, such as immune compromise need to be considered. Histological factors, such as indexed in the Brandwein-Gensler Risk Model/Score (BGS), have also been proposed for both prediction of LR and overall survival (OS). BGS parameters include worst pattern of invasion (WPOI), perineural invasion (PNI) and tumor/host interface lymphocytic infiltrate (LI). The generalizability of this model needs to be further confirmed: it has not been studied in OCSCC patients treated with TLM.

Objective: The objective of our study is to identify prognosticators for local control and survival in OCSCC patients treated by TLM \pm neck dissection \pm adjuvant therapy. In so doing, we also assess the feasibility of BGS in this cohort.

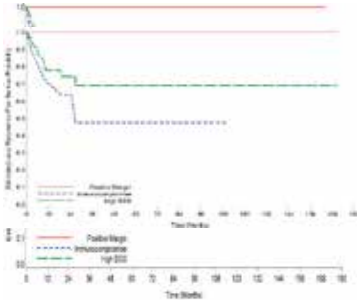
Methods: Analysis of prospectively assembled TLM-treated OCSCC patients from 1995-2010 was performed. Patients with intrinsic, iatrogenic or chronic conditions causing immunodeficiency were considered immune compromised. Local, regional and systemic disease control was recorded. Kaplan-Meier survival estimates were computed. Cox regression analyses were performed to identify variables that were independently prognostic for local control (LC), disease-specific survival (DSS), and OS.

Results: Of 95 OCSCC patients meeting criteria of minimum 24 months follow-up, BGS could be assigned to the 60 patients who comprise the study cohort (Low-BGS=28; High-BGS=32). T-stage was distributed as 27T1, 16T2, 6T3 and 11T4 (AJCC-stage I/II: 47%, III/IV: 52%). Median follow-up was 45.5 months. Four patients had positive margins at initial resection; only 1 of 4 had tumor on re-resection, thus yielding actual negative margins in 59/60 (98%) patients. Immune compromise was found in 11 (18%) patients. Adjuvant therapy was administered in 27%. Recurrences occurred in 25 patients (11 local, 14 regional and 9 distant), with more than one site in 8 patients. In multivariate analyses, immune compromise was the strongest predictor for LC, DSS and OS. T-stage was prognostic for DSS and OS, but not LC. High-versus low-BGS was significantly associated with higher local recurrences (82% vs. 18%) and distant metastases (89% vs. 11%), but was prognostic only for OS. Cox analysis could not be performed to predict DSS for high- vs. low-BGS due to no disease-related death in the latter. In the high-BGS group, 2-year LC for patients receiving adjuvant therapy versus none was 80% versus 69% (log rank=0.44). Of the BGS parameters, WPOI and PNI of larger nerves ($>1\text{mm}$) were independent prognosticators of LC, DSS and OS but LI was not.

Conclusions: We identified immune compromise as the most significant

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independent predictor of local control and survival in OCSCC treated with TLM to negative margins. We also demonstrate the feasibility of BGS risk assessment in this group. High-BGS was associated with recurrences and OS. Larger studies will be necessary to determine the adjuvant therapy-determining utility of BGS. Strategies that maintain or restore tumor-specific immune responses in immunocompromised OCSCC hosts need to be developed and applied.



S011: TRANSORAL ROBOTIC SURGERY (TORS): SIMULATION-BASED STANDARDIZED TRAINING

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Objective: To standardize introduction to transoral robotic surgery (TORS), we designed a training program based on the da Vinci Mimic Virtual Reality Simulator and tested the feasibility of training robotic surgery naïve subjects using the simulator.

Study Design: Cross-sectional prospective study

Setting: Academic tertiary referral center

Subject and Methods

Sixteen medical students with no robotic surgery experience, were trained with the simulation program on the da Vinci Surgeon Console. Participants had unlimited console time and attempts to perform 12 exercises relevant to TORS until competent. Competence was achieving an overall score $\geq 91\%$ for each exercise, calculated by preprogrammed simulator exercise metrics. Total training time (TTT) required to achieve competence was recorded, along with values for all metrics. Each participant was randomly assigned to follow-up 1, 3, 5, or 7 weeks post-training ($n=4$ per group) and repeated the exercises until regaining competence. Participants had no exposure to the console or simulation between initial training and follow-up. Follow-up total time (FTT) to re-achieve competence was recorded.

Results

All participants successfully completed training, becoming competent. Average TTT was 3.27 ± 1.22 hours. TTT distribution was bimodal rather than a normal distribution (Figure 1A), dividing the subjects into Short Training Time (STT) ($n=10$, 62.5%), and Long Training Time (LTT) ($n=6$, 37.5%) groups. TTT was 2.44 ± 0.56 hours for the STT group and 4.66 ± 0.46 hours for the LTT group ($p =$

0.0003). Difference in average time for the exercises was insignificant between STT and LTT ($p = 0.635$), but the total number of exercise attempts needed to complete training was significantly different ($p = 0.003$) with a mean 54.7 ± 14.8 and 100.2 ± 16.2 attempts respectively. STT and LTT differences in final score was insignificant ($p = 0.635$). All participants were able to re-achieve competence. Average follow-up total time (FTT) was 44 ± 5 min, 63 ± 3 min, 59 ± 23 min, and 82 ± 21 min for 1-, 3-, 5-, and 7-weeks groups respectively; all significantly shorter than TTT ($p = 0.014, 0.014, 0.029, 0.014$ respectively). The larger standard deviations at 5- and 7-weeks compared to 1- and 3-weeks were due to divergence between STT and LTT subjects (Figure 1B). While there was no significant difference between STT and LTT in average FTT for follow-up at 1 and 3 weeks ($p = 0.786$) there were significant differences in FTT at 5 and 7 weeks ($p = 0.036$). There were no differences between STT and LTT in follow-up final score ($p=0.118$).

Conclusion: Physicians in training are able to acquire and retain robotic surgery competency using the simulator but exhibit declines in skill over time during a hiatus from training. STT subjects, had a slower decline in robotic skills. Upon retraining all subjects were able to regain equivalent competence. This information can establish a simulator training program for residents prior to clinical introduction to TORS. It also provides a benchmark for determining necessary TORS surgical volume or simulator training, to maintain competency.

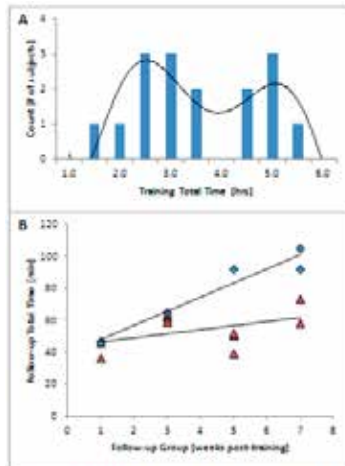


Figure 1. A) Distribution of Training Total Time. Line of best fit demonstrates a bimodal distribution ($R^2 = 0.6267$), with a clear break centered at 4.8 hrs separating Short Training Time (STT) population ($n = 10$) on the left from Long Training Time (LTT) population ($n = 6$) on the right. B) Red triangles (Δ) represent STT subjects and blue diamonds (\square) represent LTT subjects. Lines of best fit demonstrate a weak, moderately positive correlation for Short Training Time group ($R^2 = 0.216$) and a much stronger, steeper positive correlation for Long Training Time group ($R^2 = 0.944$).

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S012: ROBOT-ASSISTED COMPREHENSIVE NECK DISSECTION VIA A TRANSAXILLARY AND RETROAURICULAR ("TARA") APPROACH IN PAPILLARY THYROID CANCER WITH CERVICAL LYMPH NODE METASTASES: A COMPARATIVE STUDY WITH THE TRANSAXILLARY APPROACH

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Background: Cervical lymph node metastases are frequently encountered in the management of papillary thyroid carcinoma (PTC). Recently, robot-assisted neck dissection (ND) using a gasless transaxillary (TA) approach in thyroid cancer patients with lateral neck node metastases was studied and proven to be feasible. Here, we devised a modified transaxillary and retroauricular (TARA) approach with the addition of a retroauricular incision to the TA approach for the clearance of level II lymph nodes. The aim of this study was to compare the surgical outcomes of TARA vs. TA in the management of cervical lymph node metastases in PTC.

Methods: From October 2010 to May 2012, a total of 29 patients with PTC underwent robotic total thyroidectomy with central compartment ND, and robot-assisted modified radical ND except level I. Among the patients, 15 unilateral and 3 bilateral NDs were performed via the TARA approach, and 11 unilateral NDs were performed via the TA approach.

Results: The TA group consisted of eight females and three males, with a mean age of 43.2 years. The TARA group consisted of twelve females and six males, with a mean age of 32.6 years. There was no significant difference in operation time for ND between both groups. However, the time from skin incision to the point immediately before docking of the robotic arms was significantly longer in the TARA group, and the console time was longer in the TA group. Level II and level IV specimens in the TARA group contained a relatively larger number of lymph nodes than those in the TA group. There were no significant differences in the development of postoperative complications between both groups. All NDs were successfully performed via a robot-assisted technique.

Conclusions: Robot-assisted NDs were successfully performed via a novel TARA approach in PTC patients with cervical lymph node metastases. The surgical outcomes of robot-assisted ND via a TARA approach were comparable or even superior to those of robot-assisted ND via the transaxillary approach, especially for upper-level ND. TARA is a useful, alternative approach for addressing cervical lymph node metastases in selected cases of PTC.

S013: SURGEON EXPERIENCE AND COMPLICATIONS WITH TRANSORAL ROBOTIC SURGERY (TORS) Stanley H Chia, MD, FACS, Neil D Gross, MD, FACS, Jeremy Richmon, MD, FACS; Medstar Washington Hospital Center, Medstar Georgetown University Hospital, Oregon Health Sciences University, Johns Hopkins Hospital

Introduction: The application of transoral robotic surgery (TORS) has increased dramatically since FDA approval in 2009. Yet, there has been little published regarding perioperative care regimens for patients undergoing TORS or the frequency of postoperative complications. The aim of this study was to investigate surgeon preferences for perioperative management after TORS and to explore the frequency of postoperative complications.

Methods: A multi-institutional retrospective physician survey was performed. The survey was composed by the authors and administered electronically via surveymonkey.com. Potential participants were identified by Intuitive Surgical, Inc. as TORS-trained surgeons in the United States. Participation was voluntary and solicited by e-mail invitations to participate three times over a one month period. There was no industry participation in data acquisition, analysis or interpretation.

Results: A total of 2015 procedures were reported by forty-five respondent TORS-trained surgeons; 67% academic, 33% non-academic. Eighty-seven percent of respondents had industry-sponsored training. Nearly all respondents (91%) dedicated >50% of their practice to head and neck oncology. A minority of TORS procedures (n=214, 10.6%) were performed on previously irradiated patients. Surgeons performed neck dissections concurrently (n=26, 58%) or as a staged procedure (n=19, 42%). Fewer than 4% (n=74) of TORS procedures required tracheotomy or free tissue reconstruction. Most surgeons (62%) recommended initiation of oral intake on postoperative day 0-1. Of the patients that required readmission, bleeding (n=62, 3.1%) was the most common cause followed by dehydration (n=26, 1.3%), aspiration pneumonia (n=22, 1.1%), and airway compromise (n=4, 0.2%). Postoperative hemorrhage was most frequently managed by transoral control in the operating room (77.4%), transoral management in the outpatient setting (30.7%) and/or transcervical control in the operating room (16.1%). Other complications of surgery included tooth injury (n=29, 1.4% of all cases), PEG dependency >6 months (n=21, 1.0%), temporary hypoglossal nerve injury (n=18, 0.9%), and lingual nerve injury (n=11, 0.6%). A total of 6 deaths (0.3%) were reported within 30 days of TORS, and one death occurred after 30 days. Cause of death was reported in four cases, and all were due to postoperative hemorrhage.

Conclusions: This is the first study examining perioperative care regimens and complications encountered by a broad sampling of TORS-trained surgeons in the United States. TORS is associated with a low tracheotomy rate, a low complication rate, early initiation of oral intake and a low rate of long-term PEG dependency.

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Postoperative hemorrhage was the most common cause of hospital readmission and postoperative mortality.

S014: ANALYSIS OF POSTOPERATIVE BLEEDING IN TRANSORAL LASER MICROSURGERY OF THE OROPHARYNX

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Objective: To evaluate postoperative hemorrhage following transoral resection of oropharyngeal squamous cell carcinoma with associated risk factors and preventative measures.

Design: Multi-institution, retrospective chart review

Setting: Tertiary academic referral center, level of evidence: 2b

Patients: 906 patients treated with transoral surgery for oropharyngeal squamous cell carcinoma between 1994 and 2012 were analyzed for postoperative bleed. Tumor stage, previous treatment (surgery or radiation), resection method (laser, robot, cautery), and concomitant transcervical external carotid system ligation were analyzed in relationship to bleed presence and severity. Presentation and management of postoperative bleed was evaluated. Severity of bleed was graded as minor, major, severe, or catastrophic based on bleed control method and related sequelae.

Results: Postoperative bleed occurred in 5.4% (49/906) of patients with 32.7% (16/49) managed conservatively and 67.3% (33/49) requiring operative intervention. Transcervical external carotid system vessel ligation was performed with the primary resection in 15.6% of patients with no significant bleed rate difference between ligated (6.7%) and non-ligated (5.5%) groups ($p = 0.213$). Vessel ligation was performed more frequently in higher T-stage patients ($p = 0.002$); specifically T4 vs. T1 ($p = 0.0014$) and T3 vs. T1 ($p = 0.0049$). Intraoperative vessel ligation did not affect bleed severity. ($p = 0.526$) Numbers of severe bleeds were small ($n = 10$), only one occurred in a ligated patient.

No increase in postoperative bleed rate was seen in previously treated patients (7.8%) compared to previously untreated patients (5.4%) ($p = 0.511$). Bleed rates were similar between laser (5.6%) and robotic (5.9%) oropharyngectomy ($p = 0.799$) however, significantly larger T-stages were treated with laser surgery vs. robot (T3 vs. T1 & T3 vs. T2; $p < 0.0001$). Larger T-stage tumors had a higher bleed rate ($p = 0.015$); specifically T4 vs. T1 ($p = 0.0014$) and T3 vs. T1 ($p = 0.0049$). No difference in bleed severity was found between T-stages ($p = 0.34$). Male patients were more likely to have a bleed requiring operative intervention ($p = 0.018$).

Conclusions: Transcervical external carotid system vessel ligation performed at the time of primary oropharyngectomy does not decrease postoperative bleed rate, however, large T-stage tumors bleed more frequently and tend to be ligated more frequently. For larger T-stage tumors or previously treated patients, simultaneous vessel ligation should be considered and may reduce the severity of

a severe bleed. Procedure method (laser vs. robot) does not alter bleed rate. Male gender is correlated with increased bleed severity.

S015: SURGICAL FEASIBILITY AND ONCOLOGIC SAFETY OF ROBOT-ASSISTED NECK DISSECTION FOLLOWED BY TRANSORAL ROBOTIC SURGERY (TORS) IN HEAD AND NECK CANCER

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Introduction: Endoscopic head and neck surgery (Transoral Laser microsurgery & Transoral robotic surgery (TORS)) is no longer novel technique in head and neck cancer (HNC) treatment. But, there is few effort for minimally invasive neck dissection in HNC. We have tried to verify the possibility of Robot-assisted neck dissection (RAND) in HNC. We aimed to evaluate the surgical feasibility and oncologic safety of RAND followed by TORS, which is expected to maximize the posttreatment cosmesis and functional outcome, in HNC.

Methods: Thirty four patients who underwent TORS following RAND via a Modified facelift or retroauricular approach in cN0 or cN+ HNC were enrolled. The operation time, amount and duration of drainage, length of hospital stay, complications, number of retrieved lymph nodes, satisfaction scores, and nodal recurrence were evaluated.

Results: The primary tumor sites were found within the oropharynx for 20 patients (15 tonsil, 3 tongue-base, 2 soft palate), the hypopharynx for 8 patients, and the supraglottis for six patient. Twenty-two cases of MRND including levels I or II to V, fifteen cases of SND from level II to IV (LND), and three cases of SND from level I to III (SOND) were accomplished. Bilateral RAND were performed in six patients. The free flap reconstructions were performed in 7 cases. The mean total operating time for ND was 242 min (MRND), 199 min (LND), and 165 min (SOND), respectively and the mean postoperative hospital stay was 11.45 ± 5.2 days. The amount of postoperative drainage was 251.82 ± 131.2 mL, and the drainage duration was 5.51 ± 3.4 days. An average of 39.6 (MRND), 22.1 (LND), and 36.5 (SOND) lymph nodes was retrieved respectively. There were 4 postoperative seroma, 1 postoperative bleeding, 2 chyle leakage, 1 Honer's syndrome, and 6 temporary mouth corner deviation. Orocervical fistula didn't occur. Twenty patients underwent postoperative chemoradiation and 8 patients underwent postoperative radiation. During the follow-up period (mean of 10.3 months), all patients were alive without locoregional recurrence. All patients were extremely satisfied with their cosmetic results after the operation.

Conclusions: RANDs followed by TORS were feasible and showed a clear cosmetic benefit. Longer operation time remains the drawback of this procedure. The safety, functional, and

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oncologic outcome of the procedure should be verified with larger number of patients and longer follow up period.

S016: SIGNIFICANT FAMILIAL RISK IN MULTIPLE GENERATIONS OF PAPILLARY THYROID CARCINOMA PROBANDS

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Introduction: Papillary thyroid carcinoma has a well-recognized familial pattern. However, the specific risk to close and extended relatives of patients diagnosed with papillary thyroid carcinoma has yet to be adequately defined.

Methods:

Using the Utah Population Database, an extensive genealogical database linked to medical records and the Utah Cancer Registry, papillary thyroid carcinoma risk was calculated for 1st through 5th degree relatives and spouses of probands compared to random population-based controls matched 5:1 on sex, year of birth, and place of birth. Familial risk was estimated by calculating odds ratios using conditional logistic regression, adjusting for number of biological relatives, their degree of relatedness, and their person-years at risk. All relatives of pediatric cases and of matched controls with follow-up who linked to a pedigree of ≥ 2 generations were included. This approach has been shown to lead to unbiased familial risk estimates. As observations within families are non-independent, a robust variance estimator for cluster-correlated data was incorporated.

Results: First-, second-, and third-degree relatives of 4,460 papillary thyroid carcinoma probands diagnosed from 1966-2011 had a significant increased risk of developing this malignancy compared to population controls. First-degree relatives of probands were at 5.4-fold increased risk ($P < 10^{-15}$) of being diagnosed with this cancer themselves. Second- and third-degree relatives had a 2.2-fold ($P < 10^{-11}$) and 1.8-fold risk ($P < 10^{-8}$), respectively, of developing papillary thyroid carcinoma. Siblings of probands were at highest risk (OR=6.8, $P < 10^{-15}$). There was no significant increased risk observed in spouses of probands.

Conclusion: In the largest population study to date, a high risk of papillary thyroid carcinoma is confirmed in first degree relatives. Furthermore, significant risk extends to second- and third-degree relatives but not to spouses of probands, suggesting that this risk may have a genetic basis rather than shared environment. These findings indicate that this group will likely benefit from closer clinical attention, including collecting a 3-generation family history. Studies are needed to better define optimal screening approaches and implementation.

S017: MALIGNANCY RATE AND SUBSTRATIFICATION EFFICACY IN THYROID NODULES CLASSIFIED AS ATYPIC OF UNDETERMINED SIGNIFICANCE

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Background: The Bethesda System for reporting thyroid cytopathology is the current standard for interpreting thyroid fine needle aspiration (FNA) specimens. The Atypia of Undetermined Significance (AUS) category has an implied risk of malignancy between 5-15%, but the true incidence remains unknown. Our objective was to evaluate the prognostic role of substratifying the AUS diagnosis, while analyzing its true malignancy rate in surgical specimens.

Study Design: Retrospective cohort analysis at a comprehensive cancer center.

Methods: The management of 577 thyroid nodule patients presenting with AUS between 2007-2011 was evaluated. Patients with pre-existing or concurrent thyroid malignancies were excluded. Clinicopathologic predictors of surgery were assessed using multivariable logistic regression. Among patients undergoing surgery for diagnostic or therapeutic purposes, FNA-biopsied nodules were correlated with surgical pathology to determine the incidence of malignancy.

The AUS diagnosis was further substratified into five categories: AUS-NOS; AUS-favor benign; AUS-cannot exclude papillary thyroid carcinoma (PTC); AUS-cannot exclude Hurthle cell neoplasm; and AUS-cannot exclude follicular neoplasm. Cytologic diagnoses were correlated with findings in the thyroidectomy specimens to determine benign (goiter and lymphocytic thyroiditis) and neoplastic (benign and malignant) findings.

Results: Of all thyroid FNAs, 8.0% were classified as AUS, matching the recommended Bethesda rate. Of patients with AUS on initial FNA, 63.6% (367/577) underwent immediate surgery, 16.5% (95/577) had repeat FNA, and 16.6% (96/577) were observed. Repeat FNA revealed AUS in 38.9% (37/95), malignancy in 4.2% (4/95), and was benign in 43.2% (41/95). Of those with consecutive AUS diagnoses who went on to surgery, 36.8% (7/19) were identified with malignancy. In multivariable analysis, the only predictor of immediate surgery was calcifications on ultrasound (OR=3.8, $p=0.02$). Among all AUS nodules, the malignancy rate was 22.1% (95% confidence interval (CI), 18.7-25.6). Among AUS nodules triaged to surgery, the malignancy rate was 31.0% (95% CI, 27.2-34.9). There were separate incidental thyroid cancers in 14.2% of patients, increasing the total malignancy rate in resected specimens to 45.2%.

Upon substratification of the AUS category, the malignancy rate was significantly higher if a specific neoplasm could not be ruled out. Conversely, an AUS-favor benign diagnosis conferred a higher rate of non-malignant findings (Table 1).

Conclusions: Malignancy rates in AUS are higher than typically estimated, with 22.1-31.0% of AUS nodules found to be malignant and an additional 14.2% of glands harboring incidental cancers. Substratification also appears to improve prediction of neoplasm and selection for surgery. Emerging molecular assays may further help to triage AUS nodules

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to observation or surgery.

Table 1: Histologic correlation in each AUS subcategory

AUS cases with surgery	Benign	Malignant
AUS-NOS (n=218)	41.3% (95% CI, 36.0-46.6)	36.2% (95% CI, 29.4-42.5)
AUS-favor benign (n=13)	76.9% (95% CI, 69.2-84.6)	7.7% (95% CI, 1.9-36.0)
AUS-cannot exclude PTC (n=28)	28.6% (95% CI, 9.4-47.8)	53.6% (95% CI, 33.9-72.1)
AUS-cannot exclude Hurthle cell neoplasm (n=44)	34.1% (95% CI, 20.5-47.7)	29.5% (95% CI, 16.8-45.2)
AUS-cannot exclude follicular neoplasm (n=78)	24.4% (95% CI, 11.9-36.9)	56.4% (95% CI, 44.7-67.6)

S018: CAUSES OF EMERGENCY ROOM VISITS FOLLOWING THYROID AND PARATHYROID SURGERY

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Objectives: To describe the subset of patients requiring emergency room (ER) evaluation within 30 days of their thyroidectomy or parathyroidectomy and their associated risk factors.

Study design: Retrospective chart review

Methods: Patients undergoing thyroidectomy or parathyroidectomy between 1/1/2009 and 10/7/2010 were identified via the IRB approved thyroid/parathyroid database. Postoperative patients who visited the ER within the first 30 days following surgery were selected. Univariate two-group t-tests, Wilcoxon Mann-Whitney tests, and chi-square tests were used to evaluate the association of demographic and clinical characteristics between the patients who required ER evaluation and those who did not. Clinical characteristics evaluated included type of surgery, medical comorbidities, and proton pump inhibitor (PPI) usage. Multiple logistic regression predicted the odds of an ER visit based on presence of diabetes or proton pump inhibitor usage. Odds ratios and 95% confidence intervals were considered significant at $p < 0.05$.

Results: Of the 571 patients who underwent 652 thyroidectomy or parathyroidectomy surgeries between 1/1/2009 and 10/7/2010, 62 patients required a visit to the emergency room within our tertiary medical care system a total of 77 times for issues including paresthesias (n=28), wound complications (n=9), and weakness (n=7). Out of these emergency room evaluations, 14 hospital admissions occurred for treatment of a variety of post operative complications. There were no significant age, gender, race, or body mass index differences between the two groups. A significant association was found between the presence of diabetes ($p=0.043$) and the current use of proton pump inhibitors ($p=0.028$). When controlling for diabetes, patients taking PPIs were 1.71 times more likely to visit the emergency room than patients not on proton pump inhibitors ($p=0.045$).

Conclusions: Postoperative complications

from thyroidectomy and parathyroidectomy requiring ER evaluation are significant. Postoperative patients taking proton pump inhibitors were more likely to visit the ER than patients not on PPIs. Changes in calcium absorption with PPI usage has been documented and attributed to lower bioavailability of oral calcium in the higher gastric pH environment. Reduced calcium absorption of patients undergoing PPI therapy may be the associated with higher ER evaluation rates following thyroidectomy or parathyroidectomy.

S019: COMBINED MODALITY TREATMENT OUTCOMES FOR HEAD AND NECK CANCER: COMPARISON OF CARE AT AN ACADEMIC CANCER CENTER VERSUS ACADEMIC-TO-COMMUNITY TRANSFER, 2002 - 2012

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Objective: To evaluate differences in cancer outcomes between patients with head & neck squamous cell carcinoma who underwent primary surgical resection and postoperative adjuvant treatment at an academic center (AC) and those who underwent surgery at the AC and then received adjuvant treatment at a community-based non-AC closer to home.

Study Design: Retrospective cohort study

Methods: A retrospective cohort study was performed on all patients with primary mucosal head and neck squamous cell carcinoma treated with primary surgery followed by postoperative adjuvant radiation from 2002 to 2012. Demographic, oncologic, histologic, and adjuvant treatment data were collected. The authors then performed univariate and multivariate survival analyses of the effect of AC versus non-AC adjuvant treatment on cancer outcomes.

Results: 214 patients were included in this analysis. Significant differences in demographic variables existed between AC and non-AC groups. Patients returning home for adjuvant treatment at a community-based non-AC had a significantly lower average radiation therapy (RT) dose, fewer RT fractions, and lower dose per fraction compared to those receiving treatment at the AC. They also had significantly more RT delays, more breaks in RT, and more early termination of RT. The non-AC group had significantly lower overall survival ($p=0.013$), lower disease-specific survival ($p=0.002$), and lower locoregional control ($p=0.044$) compared to the AC treatment group. AC treatment was significantly associated with improved survival on univariate analysis (HR 0.53, 95% CI 0.32 - 0.88; $p=0.015$). This effect was not seen on multivariate survival analysis (HR 0.75, 95% CI 0.44-1.29; $p=0.30$).

Conclusion: Important differences were noted in the metrics of adjuvant radiation provided at the AC compared to those provided at the community-based non-ACs closer to the patients' homes. Significantly better oncologic outcomes were also seen in the AC adjuvant treatment group as compared to the non-AC adjuvant treatment group, including significantly improved overall survival, disease-free survival, and locoregional

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control, as noted on univariate analysis. These outcomes were not upheld on multivariate analysis, a finding that may be explained by a priori demographic and oncologic differences noted between these groups.

S020: DESIGNING THE NEXT GENERATION OF BIOREACTORS FOR STEM-CELL TRACHEAL

TRANSPLANTATION Hunter Faircloth, BS, Don Mettenberg, AS, Aaron Cunningham, BS, Matt Jones, MSECE, Madelaine Dubin, Frederick Rueggeberg, DDS, Gregory Postma, MD, Paul Weinberger, MD; Georgia Health Sciences University

BACKGROUND: Patients with large segment tracheal disease from benign processes or cancer (thyroid or squamous cell) have limited treatment options. Reconstruction of large-segment tracheal defects is difficult, and allograft transplantation with the requisite immunosuppression is not an option in patients with active malignancy. Regenerative medicine may offer a viable alternative. In 2008, a trachea was grown in an experimental bioreactor from a patient's own stem cells and successfully transplanted. Problems encountered with this process include inability to sterilize the bioreactor, implementation barriers of scale, and potential cross-contamination between repeated use of the bioreactor vessel.

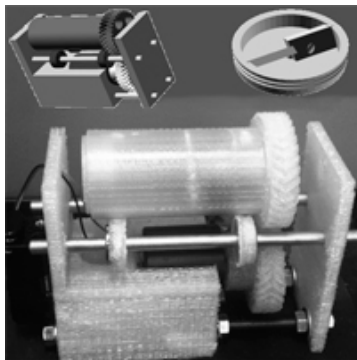
The purpose of this study was to design a second-generation bioreactor that could potentially be implemented in a wide variety of end-user clinical locations.

METHODS: We used computer aided design / computer aided manufacturing (CAD-CAM) coupled with a custom-built 3-D printing device capable of directly fabricating design components to construct a prototype second-generation bioreactor. Essential design elements included the following: 1) A two chamber system allowing for separate growth media conditions for the luminal (epithelial cells) and external (chondrocytes) graft surfaces. 2) Controlled rotation at 1 RPM to induce optimal fluid shear forces to induce chondrogenic differentiation and growth. 3) Continuous carbon-dioxide and oxygen gas exchange. 4) Single-use modular design, where the bioreactor vessel can be pre-sterilized and individually packaged. 5) Easy media exchange if required during graft culturing. The bioreactor prototype was constructed using polylactic acid (PLA), to minimize any potential biocompatibility issues.

RESULTS: The CAD-CAM system allowed rapid turnaround time (2-7 days) between iterative design changes. We successfully fabricated a final prototype bioreactor meeting all design requirements. The prototype uses a novel "rock-tumbler" based approach where the sterile chamber is essentially a modular, single use cylinder-in-cylinder that can be pre-sterilized separate from the motor and gas exchange connectors.

CONCLUSION: Our next-generation bioreactor model has the potential to allow hollow-tube organ production at large scale. The ability to test in nearly real-time, the effects of various modifications was a unique advantage of using the 3D printing system. While initially designed for growth of stem-cell

seeded trachea, it can easily be modified for future use in a variety of other applications, such as esophageal or vascular grafts. Owing to the modular design and "single-use cartridge" approach, use of stem-cell mediated regenerative techniques may eventually be feasible at a much broader range of clinical settings than previously thought possible.



S021: RISK FACTORS FOR PLACEMENT OF A PERCUTANEOUS ENDOSCOPIC GASTROSTOMY TUBE DURING CHEMORADIOTHERAPY FOR OROPHARYNGEAL SQUAMOUS CELL

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Background. Percutaneous endoscopic gastrostomy tubes may be necessary for patients with oropharyngeal squamous cell carcinoma (OPSCC) undergoing chemoradiotherapy (CRT) due to dehydration or significant weight loss. We sought to review the need for a reactive PEG tube placement and hypothesized there would be patient or tumor factors that would be associated with the need for a reactive PEG tube placement.

Methods. Of 430 patients receiving CRT for OPSCC from May 2004 through June 2012, we identified 242 patients who did not receive a prophylactic PEG tube prior to, or within, 10 days of initiation of CRT, unless an attempt to prevent upfront placement of a PEG tube was explicitly indicated in the chart. Inclusion criteria included treatment with IMRT and chemotherapy and a minimum follow-up of 3 months. Exclusion criteria were prior head and neck surgery, prior head and neck cancer, induction chemotherapy, synchronous primary or locoregional recurrence or persistence of disease within 3 months of completing CRT. Patient demographics, tumor status, treatment, as well as information regarding who reactively required a PEG tube during or 3 months following completion of CRT, were abstracted. The Mann-Whitney U test and the Pearson's Chi-square test were used to compare groups. Multivariate analysis was performed using a logistic regression model on potential predictors from univariate analysis.

Results. We identified 128 patients who did not receive a prophylactic PEG tube. Reactive

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placement of a PEG tube occurred during, or 3 months following, CRT in 15 patients (12%). Nine patients (7%) had a PEG tube at 3 months follow-up. On univariate analysis, a tumor T-stage ≥ 3 ($p=0.05$), a cumulative cisplatin dose ≥ 200 mg/m² ($p=0.03$), and the DAHANCA radiation schedule ($p=0.02$), were significantly associated with the placement of a reactive PEG tube during treatment. A BMI < 25 kg/m² showed a trend toward significance on univariate analysis ($p=0.10$). On multivariate analysis, a tumor T-stage ≥ 3 (OR 3.5, 95%CI 1.0-11.9, $p=0.03$), a cumulative cisplatin dose ≥ 200 mg/m² (OR 6.7, 95%CI 1.2-36.7, $p=0.03$), the DAHANCA radiation schedule (OR 4.2, 95%CI 1.1-16.5, $p=0.04$), and a BMI < 25 kg/m² (OR 5.8, 95%CI 1.4-23.9, $p=0.02$) were significantly associated with the placement of a reactive PEG tube.

Conclusions. Only 12% of OPSCC patients at our institution required the reactive placement of a PEG tube at some point within 3 months of the completion of CRT. A tumor T-stage ≥ 3 , a cumulative cisplatin dose ≥ 200 mg/m², the DAHANCA radiation schedule, and a BMI < 25 kg/m² are associated with symptomatic need for PEG placement.

S022: PROGNOSTIC FACTORS ASSOCIATED WITH DECREASED SURVIVAL IN ACINIC CELL CARCINOMA

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Salivary gland neoplasms represent 2-7 % of all head and neck neoplasms, but only approximately 0.5% of malignancies. Acinic cell carcinoma comprises 3-9 percent of all salivary gland neoplasm and up to 17 percent of salivary gland malignancies with the majority of occurring in the parotid gland. Although the overall survival for patients with acinic cell in generally favorable, this neoplasm does have the potential to recur both locoregional and distant sites. Given the rarity of this disease there have been only few reports on prognostic factors associated with alterations in survival outcomes. The goals of this study were to identify clinicopathologic factors associated with adverse survival as to assess the impact of local, regional, and distant recurrences on survival and furthermore.

Methods: Retrospective chart review of patients seen at MD Anderson Cancer Center from January 1970 to November 2007 with the diagnosis of acinic cell carcinoma. We 155 patients identified with mean follow-up of 6.8 years (range 0.2-38 years). The mean age at presentation was 52 years old (range 11-100).

Results: In this cohort, we observed a median survival of 28.5 years (range 0.2-38 years), with 8% (13) of patients dying from their disease. Most of these deaths, 77%, were attributed to the development of distant metastases with a mean time to death of 3.8 years (range 0.73-11.2). Women ($n=104$) were affected twice as often as men ($n=51$) but appear to have a significantly improved survival ($p<0.0001$). Patients diagnosed before the age of 45 years had a significantly improved survival ($p<0.0001$) compared

to their elder counterparts, independent of gender. The size of the neoplasm at initial diagnosis also carried prognostic significance with lesions >3 cm having a decreased overall survival ($p=0.037$). Interestingly, the presence of positive surgical margins or the addition of postoperative radiation therapy was not correlated with alterations in survival. The local, regional, and distant recurrence rates were 20%, 9%, and 19% respectively but the presence of a recurrence, independent of site, was not associated with a diminished survival. In contrast, the development of distant metastases, most frequently to the lungs, was strongly associated with death from the disease (OR: 5.5, CI:2.11 to 14.09, $p=0.0004$) while local and regional recurrences did not carry this association.

Conclusions: Acinic cell carcinoma is a rare neoplasm with a generally high survival rate. In this study we have identified several factors that are associated with poorer survival outcomes that include the male gender, age >45 years old, neoplasms > 3 cm, and the development of a recurrence at a distant metastatic site. These results suggest that maximizing local and regional control for this disease can offer substantial benefit when no distant disease is detectable. Patients with adverse risk factors should be monitored closely and aggressive adjuvant therapy should be considered for distant recurrences in this subset of patients.

S023: RACIAL AND ETHNIC DISPARITIES IN SALIVARY GLAND CANCER SURVIVAL
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Background: Several studies have documented disparities in head and neck cancer outcomes for black patients in the United States. However, few studies have been conducted to identify differences in long-term survival from salivary gland cancer amongst racial/ethnic minorities and Whites.

Methods: 6344 cases of salivary gland cancer in the National Cancer Institute's Surveillance, Epidemiology, and End Results database from 1988-2003 were analyzed. Racial/ethnic groups were studied for disease specific survival. Characteristics of each group including mean age at diagnosis, gender, tumor grade, mean size at diagnosis, extension, lymph node involvement, and treatment were determined. Groups were further analyzed by histologic subtype.

Results: Of 6344 patients, 538 (8.5%) and 253 (4%) were Black and Hispanic, respectively. Twenty-year survival rates for Whites, Blacks and Hispanics were 76%, 83% and 81%, respectively. Blacks had significantly better survival than Whites ($p = 0.015$). Hispanics also had significantly better survival than Whites ($p = 0.0363$). This is likely due to the fact that Hispanics and Blacks had significantly lower percentages of high grade tumors. Additionally, the mean age at diagnosis for Whites was 64 compared to 54 and 52 for Blacks and Hispanics, respectively.

There were 2026 cases of mucoepidermoid cancer with 11.9% and 5.2% Blacks and Hispanics, respectively. Twenty-year survival

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rates in Whites, Blacks and Hispanics were 88%, 89% and 95%, respectively. Hispanics had significantly better survival than Whites ($p = 0.049$). Hispanics had significantly higher proportions of low grade tumors and less tumor extension at the time of diagnosis when compared to both Whites and Blacks. Additionally, the mean age at diagnosis for Whites was 57 compared to 50 and 47 for Blacks and Hispanics, respectively.

1307 cases of adenocarcinoma with 7.3% and 3.7% Blacks and Hispanics, respectively, were analyzed. Twenty-year survival rates in Whites, Blacks and Hispanics were 60%, 79% and 56%, respectively. Blacks had significantly better survival than Whites ($p = 0.319$). Hispanics had poorer survival than Whites and Blacks likely due to the fact that they had larger tumor size, higher percentage of metastasis at diagnosis and lower percentage of patients receiving surgery. Whites had a mean age at diagnosis of 64 compared to 61 and 53 for Blacks and Hispanics.

There were 1448 cases of squamous cell salivary gland cancer with 5.7% and 2.4% Blacks and Hispanics, respectively. The difference in survival between the groups with squamous cell cancer was small and not statistically significant.

399 cases of acinar salivary gland cancer with 5.8% and 4.3% Blacks and Hispanics, respectively, were analyzed. Blacks and Hispanics had better survival than Whites, although sample size was small and results were not statistically significant.

Conclusions: Whites with salivary gland cancer have higher mean age at diagnosis than Blacks and Hispanics suggesting a relationship between age and survival in salivary gland cancer. Tumor characteristics likely account for the better survival observed in Hispanics when compared to Whites and Blacks with mucoepidermoid cancer. Poor access to care may be responsible for lower-than-expected survival in Blacks with mucoepidermoid cancer.

S024: MANAGEMENT OF THE NECK IN CARCINOMA OF THE PAROTID GLAND

Safina Ali, MD, Frank L Palmer, BA, Monica Whitcher, BA, Jatin P Shah, MD, Snehal G Patel, MD, Ian Ganly, MDPHd; Memorial Sloan-Kettering Cancer Center

Objectives: The objectives of our study were to review our experience in management of regional lymph nodes, in patients with carcinoma of the parotid gland, identify clinico-pathological factors predictive of neck metastases, identify neck levels pathologically positive for metastases following neck dissection and report neck recurrence rates.

Materials and Methods: This was a single institution retrospective cohort study. We identified 266 patients with previously untreated carcinomas of the parotid gland between the years 1985- 2009. Three patients were M1 at presentation and were excluded from analysis, leaving 263 patients for the study. Patient, treatment and tumor characteristics were collected by retrospective review of patient charts. Patients were stratified by neck management into 3 groups: Observation (Obs), elective neck dissection

(END) and therapeutic neck dissection (TND). The pathological positivity of each neck level was quantified for the END and TND groups. Clinico-pathological characteristics of the END group and TND group vs Obs group were compared using the Chi square test of association. Neck recurrence free survival was determined for each group using Kaplan Meier statistics.

Results:

There were 136 males and 127 females (median age 62 years). Of the 263 patients, 232 were cN0 and 31 cN+. Of the cN0 patients, 158 were selected to have neck observation and 74 END. All cN+ patients had TND. Of the END group, occult neck metastases were detected in 26 (35%) patients. The % positivity per neck level was 19.2% level I (5/26), 84.6% level II (22/26), 61.5% level III (16/26), 26.9% level IV (7/26), 15.4% level V (4/26). Of the TND group, pathological positivity was found in 86.1% patients. The % positivity per neck level was 59.3% level I (16/27), 85.2% level II (23/27), 85.2% level III (23/27), 59.3% level IV (16/27), 44.4% level V (12/27). Compared to the observation group, the END and TND groups were more likely to be over 65 yrs of age and have clinical stage T3/4 disease. Pathology showed the END and TND groups had more aggressive histology with a greater percentage high grade, vascular invasion, perineural invasion, positive margins and pT stage. The majority of patients who were pN+ in the END group (93%) and TND group (92%) had postoperative radiation (PORT). Figure 1 outlines the management of the neck in our patient groups. The Obs group and END group (pN0) had an excellent 5yr NRFS of 98.7% and 97.3% respectively. Patients who had pathologically positive neck on END or TND had a NRFS of 88.6%.

Conclusion

Patients who are cN0 who present with clinical stage T3/4 disease or high grade histology have a high rate of occult metastases involving neck levels I-IV. Patients who are pN+ managed by END or TND followed by adjuvant PORT achieve a satisfactory NRFS of 88.6%.



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S025: PROGNOSTIC FACTORS OF LOCALIZED SINONASAL MUCOSAL MELANOMA

Adil Benlyazid, MD, Thomas Filleron, PhD; Institut Claudius Regaud

Objective: To report prognostic factors of localized sinonasal mucosal melanoma (SNMM) treated in a multi-institutional setting.

Design: Retrospective review

Setting: French medical institutions.

Patients: A total of 142 patients with non-metastatic SNMM treated from 1980 through 2008 with surgery alone or surgery and postoperative radiotherapy.

Results: On univariate analysis, only T stage was significant ($p=0.001$) as a prognostic factor of 5-years relapse free survival : 42.8% for T1-2 vs 12.1% for T3-4. Locoregional control was significantly ($p=0.018$) improved by postoperative radiotherapy : the locoregional recurrence rate was 55.1% with surgery alone vs 33.2% with postoperative radiotherapy. The 5-years metastatic recurrence rate was significantly higher for T3-4 tumors (43.1% vs 21.6% for T1-2 tumors; $p=0.016$) and for sinus tumors (41.7% vs 21.6% for nasal tumors; $p=0.006$).

On multivariate analysis, T stage was found as an independent risk factor of relapse free survival (HR = 2.36 ; $p=0.003$) and locoregional control (HR = 2.02 ; $p=0.048$). The hazard ratio of metastatic spreading of sinus tumors was 2.5 ($p=0.049$) when compared to nasal tumors. Sinusal location and advanced T stage were both significantly associated to poorer 5-years overall survival.

Conclusion: This study shows that there is a clear difference between sinusal and nasal mucosal melanomas : sinusal tumors are associated to more frequent metastatic spreading and poorer prognosis. It also shows that AJCC T stage is still valid as a prognostic factor of relapse free survival, locoregional survival and overall survival.

S026: SUPRACRICOID PARTIAL LARYNGECTOMY FOR PRIMARY AND RECURRENT LARYNGEAL CANCER

Steven M. Sperry, MD, Christopher H Rassek, MD, Gregory S Weinstein, MD; University of Pennsylvania

Objective: To review the oncologic outcomes following supracricoid partial laryngectomy in a large U.S.-based cohort treated by a single surgeon

Design: Retrospective case series

Setting: Tertiary-care university hospital

Patients: 83 consecutive patients with primary or recurrent squamous cell carcinoma (SCCA) of the larynx undergoing supracricoid partial laryngectomy (SCPL) from 1997-2010.

Three radiation failure patients were converted to total laryngectomy (TL) at the time of surgery due to positive margins, and these cases were not included in the subsequent outcomes analyses.

Main Outcome Measures: 5-year local recurrence free survival and laryngeal preservation, based on the Kaplan-Meier method, stratified by prior radiation treatment

Results: There were 44 primary laryngeal tumors and 39 previously treated with radiation to the larynx; 22% were supraglottic or transglottic tumors. Of primary tumors,

there were 18T2 and 24T3 tumors. The overall 5-year local control rate for the series was 95%, and for T2 and T3 primary tumors the rate was 100% and 95%, respectively. In patients previously treated with radiation, the 5-year local control was 91%, with a 91% laryngeal preservation rate. Amongst stage III or IV primary laryngeal tumors for which concurrent chemoradiation was a treatment alternative, the 5-year local and locoregional control was 95% and 79% respectively, and the 5-year laryngectomy-free survival was 90%. Ultimate local control was achieved for all patients in the series. Hospital charts were available for 76 patients, which demonstrated a significant complication rate of 21% and no perioperative deaths. The rate of complications in previously radiated patients versus primary tumors was not significantly different. Complications included ruptured pexy ($n=2$), wound infection/fistula ($n=4$), aspiration/tracheitis ($n=4$), chyle leak ($n=4$), c. difficile colitis ($n=2$), and alcohol withdrawal ($n=1$). No total laryngectomies were performed for laryngeal dysfunction.

Conclusions: We report the largest series of laryngeal SCC treated with SCPL in the U.S. This series demonstrates excellent local control for both primary and recurrent laryngeal tumors, with functional larynx preservation. In appropriately staged and selected patients with T2 or T3 primary laryngeal tumors, or laryngeal tumors following prior radiation treatment, SCPL should be considered as a treatment alternative to radiation or total laryngectomy.

S027: IMPACT OF SURGICAL RESECTION ON SURVIVAL IN PATIENTS WITH ADVANCED REGIONAL METASTATIC HEAD AND NECK CANCER INVOLVING CAROTID ARTERY.

Nauman Manzoor, MD, Jonathon Russell, MD, Shlomo Koyfman, MD, Joseph Scharpf, MD, Brian Burke, MD, Mumtaz Khan, MD; Head and Neck Institute / Cleveland Clinic Foundation, Cleveland, Ohio, USA.

Objective: To assess the outcome of aggressive surgical management in patients with advanced head and neck cancer involving the carotid artery.

Patients and Methods: 22 patients were treated between 2006 and 2012 for overt or suspected involvement of common or internal carotid artery with metastatic head and neck cancer. Patient demographics, disease and treatment related factors were extracted from the charts retrospectively. 4 patients were treated with carotid artery resection with reconstruction using the greater saphenous vein. Recurrence and disease specific survival outcomes were compared between different groups.

Results: Median age at diagnosis was 66 years (range 31- 84). Majority of the patients were male (77%), were smokers (82 %) and had recurrent regional metastatic disease at the time of presentation (60%). 18 patients were treated primarily with surgery while the remaining 4 were treated with chemoradiation as the primary treatment modality. Intra-operatively, 9 out of the 18 patients who were treated with surgery had gross malignant invasion of the carotid artery, with 9 demonstrating involvement without invasion

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that was able to be removed completely. 4 of 9 patients with gross invasion of the carotid were treated with resection and reconstruction with the saphenous vein, while the remaining 5 patients did not have resection of the carotid. There were no major neurological complications except for 1 patient who had a post-operative stroke.

Out of the 4 patients who were treated with carotid resection, 2 died with a median survival of 3.25 months while 1 is alive with recurrence and 1 with no evidence of recurrence. In the group with unresectable carotid disease, 4 patients died with median survival of 7.15 months and 1 is alive with recurrence.

Out of the 9 patients who had complete surgical removal of tumor, 6 died with median survival of 6 months while 1 is alive with disease and 2 without disease. Out of the 4 patients who received primary chemotherapy, 2 died with median survival of 18.6 months while 2 are alive with no evidence of recurrence.

This study included both primary and recurrent head and neck cancer. Overall, patients who had a recurrent neck disease had a worse outcome (median survival = 3.9 months) compared to those whose neck disease was part of their initial presentation (median survival = 10.2 months).

Overall, 58 % of patients had local recurrence in the neck and 41 % had evidence of distant metastasis during the course of follow up after initiation of treatment for neck disease involving the carotid artery.

Conclusion: Patients with advanced head and neck cancer involving the carotid artery represent an unfortunate group with an inherent dismal prognosis. If the involvement of carotid is part of a recurrent regional metastasis, then the outcome is guarded. When disease burden merits, surgical resection and reconstruction of the carotid artery may be completed without significantly compromising overall survival.

S028: FOLATE RECEPTOR BETA TARGETING FOR IN VIVO OPTICAL IMAGING OF HEAD AND NECK SQUAMOUS CELL CARCINOMA

Joel Y Sun, Joel Thibodeaux, Gang Huang, Yiguang Wang, Jingming Gao, Philip S Low, Baran D Sumer; University of Texas Southwestern Medical Center; Purdue University

Objective: The folate receptor (FR) is a high-affinity folic acid binding endocytic receptor uncommonly expressed in normal tissues. The alpha isoform is overexpressed in a variety of epithelial neoplastic cells. In contrast, functional expression of the beta isoform is limited to activated macrophages. Importantly, in many malignancies FR serves as a convenient target for the delivery of tumor specific drugs and imaging markers. Folic acid conjugated fluorescent dyes have been used to guide tumor resection in mouse models and more recently in humans. However, their potential in HNSCC is unclear due to reported differential FR expression and an incomplete characterization of FR expression in tumors. We hypothesized that tumor infiltrating macrophages expressing FR-beta could allow fluorescent visualization of HNSCC tumors

using folate conjugated dyes even when FR expression in cancer cells is low.

Study Design: In vivo animal study and retrospective review of clinical pathologic specimens.

Setting: Academic tertiary referral center.

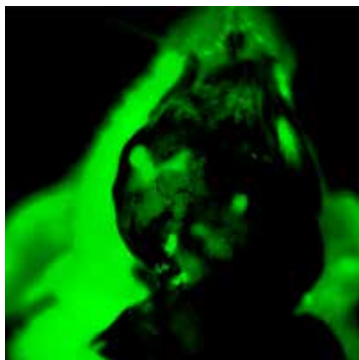
Subjects and Methods:

Immunohistochemistry was performed on a tissue microarray (TMA) containing primary tumor tissue and matched tumor free surgical margins from 22 patients who underwent HNSCC resection. Primary tumor sites included the oral tongue, base of tongue, tonsil, supraglottic larynx, glottic larynx and hypopharynx. We evaluated the expression of FR-alpha, FR-beta, transforming growth factor-beta (TGF-B), the macrophage marker CD68 and the alternatively activated macrophage marker arginase-1 using appropriate positive and negative controls for staining. Orthotopic xenograft tumor models were generated by injecting HN5 and FaDu HNSCC cell lines into the submental triangle of nude mice. The mice received 0.8 mg/kg intravenous injections of fluorescein isothiocyanate conjugated folate (Folate-FITC) and were imaged for fluorescent emission under 495nm light two hours later. Mouse tissues were then sectioned for examination using fluorescent microscopy.

Results: No FR-alpha expression was observed in any TMA tumor or normal tissue specimen. All tumor samples demonstrated strongly positive FR-beta expression. Cellular morphology and CD68 expression identified the FR-beta expressing cells as tumor infiltrating macrophages. No association was observed between FR-beta staining and TGF-B or arginase-1 staining. In the xenograft models, tumors showed strong fluorescence in vivo after folate-FITC injection. Normal salivary glands and surrounding neck muscles did not demonstrate significant fluorescence. Histologic examination of the mouse xenografts revealed that fluorescence within the tumors was confined to areas of inflammatory cell infiltration and necrosis, consistent with our TMA data.

Conclusion: HNSCC tumors contain a significant population of FR-beta expressing macrophages. In contrast to many other carcinomas, the HNSCC tumor cells in our TMA did not express FR-alpha. Despite this, folate conjugated FITC dye was able to target and specifically label tumor xenografts in mice due to the FR-beta expression on infiltrating macrophages, allowing macroscopic fluorescence imaging. Thus, the folate linked delivery of fluorescent dye into the tumor microenvironment can facilitate image guided surgery even when HNSCC tumor cells themselves do not express FR.

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S029: DECITABINE AND CISPLATIN COMBINATION THERAPY FOR HEAD AND NECK SQUAMOUS CELL CARCINOMA

Chi T Viet, DDS, PhD, Dongmin Dang, MD, Yi Ye, PhD, Brian L Schmidt, DDS, MD, PhD; New York University, Bluestone Center for Clinical Research

Cisplatin is the primary chemotherapy for head and neck squamous cell carcinoma (HNSCC). No rescue agents are available when cisplatin resistance occurs. We hypothesize that DNA methylation of key genes mediates cisplatin resistance; moreover, pre-treatment with decitabine, a demethylating agent, restores cisplatin sensitivity by mediating gene expression changes, which lead to inhibition of proliferation and reduction in cancer pain.

Objectives: 1) Evaluate the anti-proliferative effect of decitabine and cisplatin (i.e. combination treatment) on HNSCC in vitro and in a preclinical model. 2) Determine whether combination treatment reduces cancer pain. 3) Determine whether the differences in gene expression between cisplatin-sensitive and cisplatin-resistant cell lines correlate with those differences between cisplatin-sensitive and cisplatin-resistant tumors in patients. 4) Determine whether decitabine treatment in vitro reverses the gene expression differences present in the cisplatin-resistant cell lines.

Methods: SCC-25, a cisplatin-sensitive HNSCC cell line, and SCC-25/CP, a cisplatin-resistant cell line, were pre-treated with 5 μ M decitabine and then treated with cisplatin (3-300 μ M) for 48 hours. Proliferation was quantified using an MTS assay. A preclinical model was created by inoculating SCC-25/CP cells into the hind-paw of BALB/c mice. Twenty-four mice were placed into one of four treatment groups: control sham, decitabine-only, cisplatin-only, or combination treatment. Decitabine (6 mg/kg) was administered on post-inoculation days (PID) 7 and 9, and cisplatin (6 mg/kg) was administered on PID 12, 15, 18, and 21. Tumor growth was quantified. Mechanical allodynia (i.e. pain) was quantified with a paw withdrawal assay. Formalin-fixed, paraffin-embedded biopsies were obtained from HNSCC patients who underwent chemotherapy with cisplatin. Tumors were classified as either cisplatin-sensitive (RECIST 3 or 4) or cisplatin-resistant (RECIST 1 or 2). Gene expression was quantified in these two sets of samples.

Results: In the in vitro model, pre-treatment with decitabine restored cisplatin sensitivity in SCC-25/CP, the cisplatin-resistant line, and reduced the cisplatin dose required to inhibit proliferation by 50% (i.e. ED50) to levels comparable to SCC-25, the cisplatin-sensitive line. In the preclinical model, decitabine and cisplatin combination treatment resulted in significant reduction of tumor growth compared to control, whereas decitabine or cisplatin treatment alone did not. Combination treatment significantly reduced mechanical allodynia. We quantified gene expression of IGFBP-3, hMLH1, S100, and SAT1, which are genes shown to correlate with cisplatin response in other cancers. We showed that cisplatin-sensitive and cisplatin-resistant patient tumors have distinct expression profiles. Decitabine treatment of cisplatin-resistant HNSCC cells in vitro reversed gene expression toward a cisplatin-sensitive profile.

Conclusion: Decitabine restores cisplatin sensitivity in a preclinical HNSCC model, and has potential use in the HNSCC chemotherapeutic regimen for cisplatin-resistant tumors. The combination of cisplatin and decitabine significantly reduces HNSCC proliferation and HNSCC pain.

S030: USE OF RETINOBLASTOMA PROTEIN (pRB) IMMUNOHISTOCHEMICAL STAINING AS A PROGNOSTIC INDICATOR IN OROPHARYNGEAL SQUAMOUS CELL CARCINOMA.

Adam L Baker, MD, Joseph Curry, MD, Gao W, BS, Cognetti D, MD, T Zhan, PhD, V Bar-Ad, MD, M Tuluc, MD; Thomas Jefferson University, Departments of Otolaryngology, Radiation Oncology, and Pathology

Objectives and Background: Prognosis in patients with oropharyngeal cancer appears to be improved with HPV-related tumors, yet some patients that appear to be HPV-related still do poorly. The HPV E7 protein result in inactivation of pRB and thereby contributes to tumorigenesis. Our objective was to determine if additional prognostic information could be obtained from pRB staining in patients with oropharyngeal carcinoma.

Design: A retrospective cohort of all patients diagnosed with oropharyngeal squamous cell carcinoma (OPSCC) from 2006-2009 were identified. Immunohistochemical (IHC) staining for pRB was performed on tumor samples corresponding to patients within the cohort. Patients were stratified by p16 status as a surrogate for HPV positivity. Kaplan-Meier survival estimates, Cox proportional hazard regression models, and recursive partitioning trees were used for statistical analysis of the data.

Setting: Single tertiary care institution

Patients: Seventy two patients were identified with oropharyngeal cancer.

Main Outcomes Measures: Overall survival (OS) and disease free survival (DFS) were measured for each patient within the cohort, as were additional variables such as pRB status, age tobacco use.

Results: The Kaplan-Meier OS estimate for 2 and 5 year survival rate was 83.3% and 67.6%, respectively. DFS for 2 and 5 years was 76.9% and 73.8% respectively. The

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proportional hazards model found that pRb positive individuals had a decreased risk of both death ($p=0.033$) and recurrence ($p=0.004$) when compared to individuals who are pRb negative among both p16 positive or negative individuals. On recursive partitioning analysis within the p16 positive patients, there was higher risk of death of among the Rb negative tumors versus those who are pRb positive ($p=0.004$).

Conclusions: This study suggests that there is an increase in median OS and DFS in pRb positive OPSCC. pRb may offer additional prognostic in patients with OPSCC beyond currently used markers such as p16.

S031: ROLE OF HPV DNA DETECTION IN PLASMA AND SALIVA IN THE EARLY DETECTION AND PREDICTION OF RECURRENCE IN HPV POSITIVE OROPHARYNGEAL CARCINOMA

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Background: Human papilloma virus (HPV) 16 is a major causative factor in squamous cell carcinoma (SCC) of the oropharynx. Previous studies have demonstrated that HPV-16 DNA can be detected in the pre-treatment plasma and salivary rinses from these patients. Here we investigated the feasibility of HPV-16 DNA detection in both pre and post-treatment plasma and salivary rinses and its potential role as a marker of recurrent disease.

Methods: A cohort of 54 patients with oropharyngeal and unknown primary SCC with known HPV-16 tumor status, pre- and post-treatment plasma and salivary samples was assembled. Real time quantitative polymerase chain reaction was utilized and the CaSki (American Type Culture Collection, Manassas, VA) cell line, with 600 copies/ genome HPV was used to develop standard curves for the HPV viral copy number. Standard curves for HPV-16 E6 and E7 were developed using DNA extracted from CaSki cells serially diluted to 5ng, 0.5ng, 0.05ng, 0.005ng and 0.0005ng. A standard curve was also developed for the housekeeping gene -actin (2 copies/ genome). HPV-16 E6 and E7 DNA copy numbers were determined in the plasma and salivary samples and considered positive if >0.001 copy/genome. Simple sensitivity and specificity analyses were performed.

Results: Forty (74%) patients had HPV-16 detected in their primary tumors prior to treatment, and of these HPV positive patients, 5 (12.5%) recurred (Figure 1). Of the 40 patients with HPV positive tumor, 30 (75%) patients had HPV-16 DNA detected in pre-treatment samples and one (2.5%) patient had HPV-16 DNA detected in post-treatment surveillance samples. None of the patients with HPV negative tumor had detectable HPV-16 DNA in the pre-treatment samples. The one (100%) patient with HPV positive post-treatment sample ultimately developed recurrence. Of the 14 patients with HPV negative tumors and 29 patients with HPV positive tumors who did not recur, none were HPV-16 positive in post-treatment plasma and saliva. The sensitivity,

specificity, negative predictive value (NPV) and positive predictive value (PPV) of pre-treatment combined salivary-based and plasma-based HPV-16 DNA status are 75%, 100%, 58% and 100% respectively (Table 1). The sensitivities of saliva or plasma alone were 64.86% and 63.64%, respectively. The presence of HPV-16 DNA in post-treatment plasma and salivary rinse was 100% specific and 25% sensitive in detecting loco-regional or metastatic recurrence (Table 2).

Conclusion:

Using a combination of pre-treatment plasma and salivary rinses can increase the sensitivity of pre-treatment HPV-16 status as a tool for screening patients with HPV positive oropharyngeal HNSCC. In addition, patients with the presence of HPV-16 DNA in surveillance plasma or salivary rinse may be at a significant risk of developing recurrence. Quantitative analysis of HPV-16 DNA in salivary rinses after primary treatment may allow for early detection of recurrence in patients with HPV positive oropharyngeal HNSCC.



Table 1. Sensitivity, specificity, and predictive values of pre-treatment combined saliva and plasma HPV-16 status

Tumor HPV-16 status	Pre-treatment salivary HPV-16 status		Sensitivity = 30/40 = 75% Specificity = 14/14 = 100%
	Positive	Negative	
Positive	30	10	PPV = 30/30 = 100% NPV = 14/24 = 58.33%
Negative	0	14	

Table 2. Sensitivity, specificity, and predictive values of post-treatment combined saliva and plasma HPV-16 status in HPV-16 positive tumor

Recurrence	Post-treatment salivary HPV-16 status		Sensitivity = 1/4 = 25% Specificity = 35/35 = 100%
	Positive	Negative	
Positive	1	4	PPV = 1/1 = 100% NPV = 35/39 = 89.74%
Negative	0	35	

S032: PREVENTION OF DEPRESSION USING ESCITALOPRAM IN PATIENTS UNDERGOING TREATMENT FOR HEAD AND NECK CANCER

William Lydiatt, MD, Diane Bessette, PA, Kendra Schmid, PhD, Harlan Dayles, MS, William Burke, MD; Nebraska Medical Center and Nebraska Methodist Hospital

Context: Major depressive disorder develops in up to half of patients undergoing treatment for head and neck cancer resulting in significant morbidity. Preventing depression during the course of cancer treatment may, thus, be of great benefit.

Objective: To determine whether prophylactic use of the antidepressant escitalopram would decrease the incidence of depression in

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subjects receiving primary therapy for head and neck cancer.

Design, Setting, Participants and Outcome Measures: A randomized, double-blind, placebo-controlled trial of escitalopram versus placebo was conducted in a group of non-depressed subjects diagnosed with head and neck cancer who were about to enter cancer treatment. Subjects were stratified by gender, site, stage (early versus advanced), and by primary modality of treatment (radiation versus surgery). The primary outcome measure was the number of participants who developed moderate or greater depression (scores on the Quick Inventory of Depressive Symptomatology-Self Rated > 11).

Results: From January 6, 2008 to December 28, 2011, 148 patients were randomized. Significantly fewer subjects receiving escitalopram developed depression (24.6% placebo vs. 10% escitalopram, stratified log-rank test $p=0.04$). A Cox proportional hazard regression model compared the two treatment groups after controlling for age, baseline smoking status, and stratification variables. The hazard ratio of 0.37 (95% CI: 0.14, 0.96) demonstrated an advantage of escitalopram ($p=0.04$). Patients undergoing radiotherapy as the initial modality were significantly more likely to develop depression than those receiving surgery (radiotherapy, compared to surgery group, HR 3.6 [95%CI: 1.38, 9.40, $p=0.009$]). Subjects in the escitalopram group who completed the study and were not depressed rated their overall quality of life as significantly better for 3 consecutive months following cessation of drug.

Conclusions: In non-depressed subjects undergoing treatment for head and neck cancer, prophylactic escitalopram reduced the risk of developing depression by more than 50%. In non-depressed subjects who completed the trial, quality of life was also significantly better for 3 consecutive months following cessation of the drug in the escitalopram group. These findings have important implications for management of head and neck patients.

Trial Registration: ClinicalTrials.gov Protocol Registration System, ID=NCT00536172, <https://register.clinicaltrials.gov/prs/app/action/SelectProtocol?sid=S00017GX&selection=View&uid=U0000GD7&ts=6&cx=-a81t4>

S033: SIGNIFICANCE OF PIK3CA MUTATIONS IN OROPHARYNGEAL SQUAMOUS CELL CARCINOMA [Andrew B Sewell, MD](#), Natalia Isaeva, PhD, Wendell G Yarbrough, MD, MMHC, FACS; Yale University, Vanderbilt University

Despite the shared histology of HPV-positive (HPV+) and HPV-negative (HPV-) oropharyngeal squamous cell carcinoma (OPSCC), HPV(+) tumors have fewer cytogenetic abnormalities and fewer mutations than HPV(-) tumors, confirming different mechanisms driving tumor development and progression. Previously, we found that up to 40% of HPV(+) tumors harbor PIK3CA mutations, which are involved in tumorigenesis and represent an emerging potential target for drug therapy.

Many Phase II studies have demonstrated the safety and efficacy of various PI3K/AKT/mTOR inhibitors in patients with breast, lung, and prostate cancer with PIK3CA mutations. However, we have discovered that OPSCC tumors with activating mutations of PIK3CA did not have significantly activated levels of the downstream targets, including AKT and mTOR, most likely due to increased levels of the tumor suppressor PTEN.

Using a combination of genomic profiling and proteomic studies, we screened 40 prospectively collected OPSCC tumors (23 HPV+, 17 HPV-) for the most common cancer-related PIK3CA mutations. We detected three PIK3CA mutations in eight tumors, with known activating mutations (exon 9, E542K, E545K) seen in 7 tumors; one tumor had a mutation which has been shown to be functionally indistinguishable from wild-type PIK3CA. All of the mutant tumors were detected in HPV(+) patients (7/23, 30.4%). Interestingly, in these similarly treated patients, 5-year disease-free survival was 100% in HPV(+) PIK3CA mutant patients, versus 61% in HPV(+) PIK3CA wild-type. These data suggest that PIK3CA mutations may be beneficial and may represent a positive prognostic marker for OPSCC patients receiving traditional chemo- and radiotherapy. Reverse phase protein array (RPPA) probed with 137 antibodies and analyses demonstrated that PIK3CA mutants and wild-type tumors separate into two groups with distinct protein expression profiles, including down-regulated proteins (ERK2, MRE11, mTOR, caspases 3 and 7) and up-regulated proteins (PTEN, p100, and E-cadherin, among others) in mutant specimens. In contrast, there was no significant difference in phosphorylation of p70S6K, mTOR, and AKT. Immunoblotting for randomly selected tumors, including HPV(+) PIK3CA mutant and wild-type tumors, validated RPPA findings. Activation of downstream targets of PIK3CA signaling can be blocked at several levels, including activation of phosphatases, and/or inhibition of kinase activity. Since we found that the protein levels of the tumor suppressor PTEN were increased in PIK3CA mutant tumors, we suggest that up-regulation of PTEN inhibits PI3K activity by dephosphorylating phosphatidylinositol.

Although there are many PI3K/AKT/mTOR inhibitors in clinical trials for different types of cancer, it is very important to determine in pre-clinical studies if these inhibitors are effective in PIK3CA-mutant OPSCC tumors. Two available HPV(+) HNSCC cell lines, UM-SCC-47 and UT-SCC-090, harbor wild-type PIK3CA; therefore, E542K and E545K mutations were introduced into wild-type PIK3CA vector using site-directed mutagenesis, and stably overexpressed in HPV(+) cells to perform both short-term cell viability and long-term clonogenic survival assays with the PI3K/AKT/mTOR inhibitors BEZ-235, MK-2206, and GDC-0941. Stable PIK3CA-mutant clones were implanted into NUDE mice to evaluate the *in vivo* sensitivity of PI3K/AKT/mTOR inhibitors. Future directions and detailed results will be discussed.

Poster Listing

P001 (COSM Poster #051) EXPRESSION PROFILE AND IN VITRO BLOCKADE OF PD-1/PD-L1 IN PATIENTS WITH HEAD AND NECK SQUAMOUS CELL CARCINOMA

Ian-James Malm, Tullia C Bruno, PhD, Mikhail Gorbounov, BA, Janis Taube, MD, Charles Drake, MD, PhD, Young Kim, MD, PhD; Johns Hopkins Medical Institutions

P002 (COSM Poster #052) PD-1 BLOCKADE COMBINED WITH TEGVAX (TLR AGONISTS-ENHANCED GVAX) CAN INDUCE REGRESSION OF ESTABLISHED PALPABLE TUMORS

Ian-James Malm, BA, Juan Fu, MD, PhD, Qi Zheng, MD, PhD, Drew Pardoll, MD, PhD, Young J Kim, MD, PhD; Johns Hopkins Medical Institutions

P003 (COSM Poster #053) THE ROLE OF THE PD-1:PD-L1 PATHWAY IN INNATE AND ADAPTIVE IMMUNE RESISTANCE IN HPV NEGATIVE HEAD AND NECK CANCERS.

Geoffrey D Young, MD, PhD, Belinda Akpeng, Justin A Bishop, MD, William H Westra, MD, Suzanne L Topalian, MD, Drew M Pardoll, MD, PhD, Sara I Pai, MD, PhD, Shiwen Peng; Departments of Otolaryngology-Head and Neck Surgery, Surgery, Oncology, and Pathology, The Johns Hopkins University School of Medicine, Baltimore, MD, USA.

P004 (COSM Poster #054) MULTITIER COMPUTATIONAL GENETIC ANALYSIS IDENTIFIES IMMUNE PATHWAYS ASSOCIATED WITH INCREASED SUSCEPTIBILITY TO HPV-ASSOCIATED HEAD AND NECK CANCER

Chaya Levovitz, Sarah Alshawish, Weijia Zhang, PhD, Paolo Boffetta, MD, MPH, Andrew Sikora, MD, PhD; Mount Sinai School of Medicine

P005 (COSM Poster #055) SENSORY NEURONS REGULATE HEAD AND NECK SQUAMOUS CELL CARCINOMA PROLIFERATION AND GENE EXPRESSION.

Scott H Troob, MD, Andrea N Flynn, PhD, Yi Ye, PhD, Chi T Viet, DDS, PhD, Brian L Schmidt, DDS, MD, PhD; Department of Otolaryngology - Head and Neck Surgery, New York University Langone Medical Center and Bluestone Center for Clinic Research, New York University, New York, NY

P006 (COSM Poster #056) OCT-4 STEM CELL GENE IS OVEREXPRESSED IN ORAL SQUAMOUS CELL CARCINOMA

Maria Fernanda D Rodrigues, PhD, Flavia Calo A Xavier, PhD, Eloiza H Tajara, PhD, Head and Neck Genome Project Gencapo, Fabio D Nunes, PhD; Department of Oral Pathology, Dental School University of São Paulo, São Paulo-SP, Brazil

P007 (COSM Poster #057) MALIGNANT TRANSFORMATION OF MURINE 3T3 CELLS BY CO-CULTURING WITH NASOPHARYNGEAL CARCINOMA CELLS

Wen-son Hsieh, Dr, Fredrik Petersson, Associate, professor, De -Yun Wang, Associate, professor, Kwok Seng Loh, Associate, professor, Fenggang Yu, PhD; National University of Singapore

P008 (COSM Poster #058) RECURRENT GENOMIC ALTERATIONS OF FHIT GENE WITH IMPACT ON LYMPHATIC METASTASIS IN EARLY ORAL SQUAMOUS CELL CARCINOMA

Inn-Chul Nam, MD, Young-Hoon Joo, MD, Kwang-Jae Cho, MD, Sung-Won Park, Yeon-Soo Lee, MD, Yeun-Jun Chung, MD, Min-Sik Kim, MD; The Catholic University of Korea

P009 (COSM Poster #059) GENE EXPRESSION ALTERATIONS ASSOCIATED WITH TP53 LOSS AND AGGRESSIVE BEHAVIOR IN AN ORTHOTOPIC MOUSE MODEL OF HEAD AND NECK SQUAMOUS CELL CARCINOMA (HNSCC)

Thomas J Ow, MD, MS, Vlad C Sandulache, MD, PhD, Daisuke Sano, MD, PhD, Pickering R Curtis, PhD, Heath D Skinner, MD, PhD, Mitchell Frederick, PhD, Wang Jing, PhD, Jiexin Wang, MS, Zhao Mei, MD, Tongxin Xie, MD, PhD, Harris M Thomas, PhD, Prystowsky B Michael, MD, PhD, Richard V Smith, MD, Lleras A Roberto, MS, Belbin J Thomas, PhD, Myers N Jeffrey, MD, PhD; Albert Einstein College of Medicine; Montefiore Medical Center; University of Texas, MD Anderson Cancer Center

P010 (COSM Poster #060) COLLAGEN, TYPE XIV, ALPHA 1 PROMOTER HYPERMETHYLATION IS ASSOCIATED WITH ADVANCED SALIVARY GLAND ADENOID CYSTIC CARCINOMA

Marietta Tan, MD, Chunbo Shao, MD, PhD, Justin A Bishop, MD, Elana J Fertig, PhD, Michael Considine, MS, William H Westra, MD, Patrick K Ha, MD; Departments of Otolaryngology-Head and Neck Surgery, Pathology, and Oncology Biostatistics, Johns Hopkins Medical Institutions, Baltimore, MD, USA; Milton J. Dance Jr. Head and Neck Center, Greater Baltimore Medical Center, Baltimore, MD, USA

P011 (COSM Poster #061) TUMOR-ASSOCIATED ENDOTHELIAL CELLS PROMOTE TUMOR METASTASIS BY CHAPERONING CIRCULATING TUMOR CELLS AND PROTECTING THEM FROM ANOIKIS

Arti Yadav, MS, Bhavna Kumar, MS, Jun-Ge Yu, MD, Matthew Old, MD, Theodoros N Teknos, MD, Pawan Kumar, PhD; Department of Otolaryngology-Head and Neck Surgery and Comprehensive Cancer Center, The Ohio State University, Columbus, OH 43210

P012 (COSM Poster #062) THE TUMOR PROMOTING CHEMOKINES GRO- α AND IL-8 ARE UP-REGULATED IN HEAD AND NECK SQUAMOUS CELL CARCINOMA.

Tammara L Watts, MD, PhD, Ruwen Cui, BA; University of Texas Medical Branch

P013 (COSM Poster #063) CLINICAL AND MOLECULAR DIFFERENCES BETWEEN SMOKERS AND NONSMOKERS WITH ORAL TONGUE CANCER

Ryan Li, MD, Carole Fakhry, MD, MPH, Wayne M Koch, MD, Nishant Agrawal, MD; Johns Hopkins Medical Institutions-Department of Otolaryngology/Head and Neck Surgery

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P014 (COSM Poster #064) TMEM16A, A FUNCTIONALLY ACTIVE ION CHANNEL IN H&N CANCER AND POTENTIAL TARGET FOR ENHANCING CYTOTOXIC THERAPIES Jason Kass, MD, PhD, Dong Xiao, PhD, Douglas Holt, BS, Carol Bertrand, PhD, Umamaheswar Duvvuri, MD, PhD; University of Pittsburgh Medical Center, Veteran Affairs Medical Center

P015 (COSM Poster #065) INHIBITION OF PROTEIN ARGININE METHYLTRANSFERASE-5 (PRMT-5) DECREASES CELL GROWTH, DIVISION, AND MIGRATION IN HEAD AND NECK SQUAMOUS CELL CARCINOMA Brian Boyce, MD, Matthew Old, MD, Theodoros Teknos, MD, Robert Baiocchi, MD, Manchao Zhang, Quintin Pan, PhD; The Ohio State University

P016 (COSM Poster #066) GENE EXPRESSION PROFILE OF HNSCC CANCER STEM CELLS Vivian F Wu, MD, MPH, Sudha Krishnamurthy, PhD, Maureen Sartor, PhD, Mark E Prince, MD, Jacques E Nor, DDS, MS, PhD; University of Michigan

P017 (COSM Poster #067) BIOLOGICAL MARKERS AS PREDICTORS OF CLINICAL OUTCOME IN ADENOID CYSTIC CARCINOMA OF THE HEAD AND NECK Minoru Toyoda, MD, Koichi Sakakura, MD, Kyoichi Kaira, MD, Yuki Yokobori, MD, Kazuaki Chikamatsu, MD; Department of Otolaryngology-Head and Neck Surgery, Gunma University Graduate School of Medicine

P018 (COSM Poster #068) EVALUATION OF WT1 PROMOTER METHYLATION IN SALIVARY ADENOID CYSTIC CARCINOMA (ACC) Ryan H Sobel, MD, Marietta Tan, MD, Chunbo Shao, PhD, Justin Bishop, MD, Elana J Fertig, PhD, Patrick K Ha, MD; Johns Hopkins Medical Institutions, Baltimore, MD, USA; Milton J Dance Jr Head and Neck Center, Greater Baltimore Medical Center, Baltimore, MD, USA

P019 (COSM Poster #069) HIGHLY AGGRESSIVE HPV-RELATED OROPHARYNGEAL CANCER: CLINICAL, RADIOLOGIC, AND PATHOLOGIC CHARACTERISTICS Azeem Kaka, MD, Bhavna Kumar, MS, Pawan Kumar, MS, PhD, Paul E Wakely Jr., MD, Claudia M Kirsch, MD, Matthew O Old, MD, Amit Agrawal, MD, Enver Ozer, MD, Ricardo L Carrau, MD, David E Schuller, MD, Farzan Siddiqui, MD, PhD, Theodoros N Teknos, MD; The Ohio State University, Henry Ford Health System

P020 (COSM Poster #070) EXPRESSION OF THE WILMS' TUMOR 1 GENE IN VASCULAR ANOMALIES OF THE HEAD AND NECK Chun-Yang Fan, MD, PhD, John R Sims, BS, Gresham T Richter, MD, Yuemeng Dai, MD, PhD, James Y Suen, MD; University of Arkansas for Medical Sciences

P021 (COSM Poster #071) THE IMPACT OF TISSUE HANDLING FACTORS ON PHOSPHORYLATED BIOMARKERS IN HEAD AND NECK CANCER BIOSPECIMENS Jacob I Tower, Mark W Linggen, DDS, PhD, Tanguy Y Seiwert, MD, Alexander Langerman, MD; University of Chicago

P022 (COSM Poster #072) SERUM BIOMARKERS IN HEAD AND NECK SQUAMOUS CELL CANCER Nadine Kaskas, Tara Moore-Medlin, Gloria McClure, John Vanchiere, MD, Cherie-Ann Nathan, MD, FACS; Department of Otolaryngology/Head and Neck Surgery, Department of Microbiology and the Feist-Weiller Cancer Center, LSU Health Sciences Center, Shreveport, Louisiana

P023 (COSM Poster #073) FRACTAL ANALYSIS OF NUCLEAR HISTOLOGY INTEGRATES TUMOR AND MICROENVIRONMENT INTO A SINGLE PROGNOSTIC FACTOR IN OSCC Pinaki Bose, PhD, Kevin Hynes, MSc, Elizabeth Kornaga, MSc, Nigel T Brockton, PhD, Mauro Tambasco, PhD, Joseph C Dort, MD, Alexander C Klimowicz, PhD; Ohlson Research Initiative, Southern Alberta Cancer Research Institute, University of Calgary

P024 (COSM Poster #074) CHARACTERIZATION OF 22Q13.31 REGION AND ITS ASSOCIATION WITH TUMOR SUPPRESSOR GENES IN HEAD AND NECK CARCINOMAS Fernanda B Bertonha, PhD, Mateus C Barros Filho, MsC, Hellen Kuasne, MsC, Luiz P Kowalski, PhD, Claudia A Rainho, PhD, Silvia R Rogatto, PhD; Universidade Estadual Paulista (UNESP); Hospital AC Camargo; Londrina State University

P025 (COSM Poster #075) ERBB FAMILY IS PREDICTOR OF POOR OUTCOMES IN ORAL CANCER PATIENTS WITH CAPSULAR RUPTURE IN THE LYMPH NODES Sabrina Daniela Silva, PhD, Moulay A Alaoui-Jamali, PhD, Michael Hier, Dr, Edgard Graner, PhD, Luiz Paulo Kowalski, PhD; McGill University, AC Camargo Hospital, School of Dentistry of Piracicaba

P026 (COSM Poster #076) ALTERATION OF COPIES NUMBER AND METHYLATION OF TUMOR SUPPRESSOR GENES INVOLVED IN CARCINOGENESIS OF CARCINOMA EX-PLEOMORPHIC ADENOMA Fernanda V Mariano, DDS, PhD, Rogério O Gondak, DDS, PhD, Ricardo D Coletta, DDS, PhD, Albina Altemani, MD, PhD, Oslei P Almeida, DDS, PhD, Luiz P Kowalski, MD, PhD; Department of Oral Diagnosis, Piracicaba Dental School, University of Campinas (UNICAMP)/ Department of Pathology, Medical Sciences Faculty, University of Campinas (UNICAMP)/ Department of Head and Neck, AC Camargo Hospital, São Paulo

P027 (COSM Poster #077) RELATIONSHIP BETWEEN PAPILLARY THYROID CANCER, BRAFV600E AND FUNCTIONAL BIOMARKERS OF DISEASE Edward Shin, MD, Joe Rousso, MD, Ashlie Darr, MD, James P Azzi, MD, Raj Tiwari, PhD, Jan Geliebter, PhD, Theodore Nowicki, PhD, Nicolas Kummer, MD, Melanie MacEwan, PhD; NYCC NYMC

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P028 (COSM Poster #078)

RADIOSENSITIZATION OF HPV POSITIVE HEAD AND NECK SQUAMOUS CELL CARCINOMAS (HNSCC) BY CHK1 INHIBITION

Chia-Jung Busch, Dr, Thorsten Rieckmann, Dr, Simon Laban, Dr, Cordula Petersen, Prof, Dr, Rainald Knecht, Prof, Dr, Ekkehard Dikomey, Prof, Dr, Malte Kriegs, Dr; Department of Otorhinolaryngology and Head and Neck Surgery, Head and Neck Cancer Center of the University Cancer Center Hamburg, University Medical Center Hamburg Eppendorf, Hamburg, Germany

P029 (COSM Poster #079) OPTIMIZATION OF RADIOSENSITIZING STRATEGIES USING REAL-TIME MAGNETIC RESONANCE IMAGING (MRI) IN ANAPLASTIC THYROID CANCER

Vlad C. Sandulache, MD, PhD, Heath D Skinner, MD, PhD, Yunyun Chen, PhD, Jaehyuk Lee, PhD, Christopher M Walker, BS, James A Bankson, PhD, Stephen Y Lai, MD, PhD; Baylor College of Medicine, U.T.M.D. Anderson Cancer Center

P030 (COSM Poster #080) THERAPEUTIC POTENTIALS OF HISTONE DEACETYLASE INHIBITORS FOR CANCER STEM CELL-LIKE PHENOTYPE IN SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK

Koichi Sakakura, MD, PhD, Takaaki Murata, MD, PhD, Minoru Toyoda, MD, Yuki Yokobori, MD, Kazuaki Chikamatsu, MD, PhD; Department of Otolaryngology-Head and Neck Surgery, Gunma University Graduate School of Medicine

P031 (COSM Poster #081) NOVEL TREATMENT OF HYPOPHARYNGEAL CANCER USING DACHT-LOADED POLYMERIC MICELLE

Miwako Kimura, MD, PhD, H Cabral, PhD, Y Miura, PhD, M R Kano, MD, PhD, S Tanaka, PhD, H Nishihara, MD, PhD, Y Matsumoto, MD, PhD, K Toh, PhD, N Nishiyama, PhD, K Kataoka, PhD; Department of Otolaryngology, International University of Health and Welfare, Sanno Hospital

P032 (COSM Poster #082) SALIVA FROM ORAL CANCER PATIENTS PROMOTES HNSCC GROWTH, WHILE CURCUMIN TREATMENT RESULTS IN DECREASED EXPRESSION OF SALIVARY CYTOKINES

Saroj Basak, PhD, Suejung G Kim, BS, Alborz Zinabadi, BS, Meera Srivastava, PhD, Eri S Srivatsan, PhD, Marilene B Wang, MD; UCLA David Geffen School of Medicine, VA Greater Los Angeles Healthcare System

P033 (COSM Poster #083) C-FOS/ACTIVATOR PROTEIN-1 INHIBITOR PREVENTS LYMPH NODE METASTASIS WITH HEAD AND NECK CANCER IN ORTHOTOPIC IMPLANTATION MODEL

Daisuke Kamide, MD, Taku Yamashita, MD, PhD, Koji Araki, MD, PhD, Masayuki Tomifuji, MD, PhD, Shunichi Shiozawa, MD, PhD, Akihiro Shiotani, MD, PhD; Department of Otolaryngology-Head and Neck Surgery, National Defense Medical College of Japan, Department of Medicine, Kyushu University Beppu Hospital of Japan

P034 (COSM Poster #084)

ENHANCEMENT OF ANTITUMOR ACTIVITY OF OHSV (34.5ENVE) FOR HEAD AND NECK SQUAMOUS CELL CARCINOMA CELLS BY BORTEZOMIB

Matthew Old, MD, Jun-Ge Yu, MD, Ji Y Yoo, Brian Hurhuiz, Chelsea Boyard, Quintin Pan, PhD, Pawan Kumar, PhD, Bhavna Kumar, Theodoros Teknos, MD, Balveen Kaur, PhD; James Comprehensive Cancer Center, Wexner Medical at The Ohio State University

P035 (COSM Poster #085) THE PRO-TUMORIGENIC ROLE OF TLR2 IN HEAD AND NECK SQUAMOUS CELL CARCINOMA

Lovisa Farnebo, MD, PhD, Ferenc Scheeren, PhD, Yunqin Lee, BS, Michael Clarke, MD, John B Sunwoo, MD; 1Institute for Stem Cell Biology and the Ludwig Cancer Center, 2Department of Otolaryngology, Head and Neck Surgery, 3Department of Internal Medicine, Division of Oncology, 4Stanford Immunology Program, Stanford University School of Medicine.

P036 (COSM Poster #086) SUBEROYLANILIDE HYDROXAMIC ACID (SAHA) - MEDIATED REACTIVATION OF TUMOR SUPPRESSOR MICRORNAS IN HEAD AND NECK CANCER

Jharna Datta, PhD, Mozaffar Islam, PhD, Quintin Pan, PhD, Theodoros N Teknos, MD; Department of Otolaryngology-Head and Neck Surgery, Arthur G. James Cancer Hospital and Richard J. Solove Research Institute and Comprehensive Cancer Center, The Ohio State University, Wexner Medical Center, Columbus, OH 43210, USA

P037 (COSM Poster #087) POLYMER ENCAPSULATION OF CPT: A PROMISING NOVEL THERAPEUTIC FOR HEAD AND NECK SQUAMOUS CELL CARCINOMA

Luis E Santaliz-Ruiz IV, MD, Zhun Zhou, BS, Theodoros Teknos, MD, Dennis Bong, PhD, Quintin Pan, PhD; Department of Otolaryngology-Head and Neck Surgery, Comprehensive Cancer Center, The Ohio State University Medical Center, & Department of Chemistry, The Ohio State University, Columbus, Ohio, USA.

P038 (COSM Poster #088) GENETIC AND CHEMICAL TARGETING OF EPITHELIAL-RESTRICTED WITH SERINE BOX REDUCES EPIDERMAL GROWTH FACTOR RECEPTOR AND POTENTIATES THE EFFICACY OF AFATINIB

M Zhang, PhD, Ce Taylor, PhD, J Datta, PhD, S Bhavne, PhD, Tz Su, PhD, Jc Lang, PhD, Tn Teknos, MD, Ak Mapp, PhD, Q Pan, PhD; Department of Otolaryngology-Head and Neck Surgery, The Ohio State University Medical Center, Columbus, OH 43210; Department of Chemistry, University of Michigan, Ann Arbor, MI 48109

P039 (COSM Poster #089) EFFECT OF E6, E7 AND E2 SILENCING ON GENE PATTERN IN HPV POSITIVE HUMAN HEAD AND NECK SQUAMOUS CANCER CELL LINES

Monika J Agrawal, PhD, Manish K Patel, MS, Seunghee Kim-Schulze, PhD, Marshall Posner, MD; The Tisch Cancer Institute Division of Hematology/Medical Oncology Mount Sinai School of Medicine, New York

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P040 (COSM Poster #090) COMBINED INHIBITION OF COX2 AND INOS SUPPRESSES TUMOR-INFILTRATING MYELOID CELLS AND INHIBITS GROWTH OF METASTATIC HEAD AND NECK SQUAMOUS CELL CARCINOMA IN A MURINE MODEL Peter Svider, BA, Erden Goljo, BA, Nathaniel Villanueva, BS, Padmini Jayaraman, PhD, Matthew Alfarano, BA, Esther L Rivera, PhD, Falguni Parikh, MS, Yeriell Estrada, BA, Julio Aguirre-Ghiso, PhD, Andrew G Sikora, MD, PhD; Mount Sinai School of Medicine, Department of Otolaryngology, Tisch Cancer Institute, Head and Neck Cancer Research Program, Immunology Institute

P041 (COSM Poster #091) THE MANAGEMENT OF EARLY GLOTTIC CANCER IN A VETERANS AFFAIRS MEDICAL CENTER PATIENT COHORT: IMPACT OF RISK FACTORS ON DISEASE RECURRENCE AND TREATMENT ALGORITHMS. Vlad C. Sandulache, MD, PhD, Alexander H Gelbard, MD, Mark W Kubik, Joseph A Malsky, Earlie H Thorn, Jose P Zevallos, MD

P042 (COSM Poster #092) PREVALENCE OF HIGH-RISK HPV IN UNKNOWN PRIMARY SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK Shane Gailushas, MD, David Yang, MD, Paul Harari, MD, Gregory Hartig, MD; University of Wisconsin Hospital

P043 (COSM Poster #093) EFFECT OF SOCIOECONOMIC STATUS ON PERI-OPERATIVE MORBIDITY IN HEAD AND NECK CANCER PATIENTS Caroline C Xu, MD, Andre Isaac, Peter T Dziegielewski, MD, FRCSC, Daniel A O'Connell, MD, FRCSC, Jeffrey R Harris, MD, FRCSC, Hadi Seikaly, MD, FRCSC; University of Alberta

P044 (COSM Poster #094) CONCORDANCE RATES OF HEAD AND NECK TUMOR CLINICAL STAGING VS. PATHOLOGICAL STAGING IN A TERTIARY CARE CENTER: HOW ACCURATE ARE WE? Paul D Kim, MD, Kien Tran, MSII, Niklaus Eriksen, MD; Loma Linda University

P045 (COSM Poster #095) SURGICAL MANAGEMENT OF SYMPTOMATIC VERTEBRAL ARTERY COMPRESSION BY THE SUPERIOR CORNU OF THE THYROID CARTILAGE Maria C Buniel, MD, Shannon Kraft, MD, Gary M Nesbit, MD, Helmi L Lutsep, MD, Joshua S Schindler, MD, Bronwyn E Hamilton, MD; Oregon Health and Science University, Portland, OR USA

P046 (COSM Poster #096) PROSPECTIVE STUDY TO COMPARE CLINICAL, RADIOGRAPHIC AND PATHOLOGIC DEPTH MEASUREMENT IN ORAL TONGUE SQUAMOUS CELL CARCINOMA Hussain A Alsaffar, MBBS, FRCSC, Jonathan C Irish, MD, MSc, FRCSC, FACS, Colleen Simpson, Research, Coordinator, David Goldstien, MD, FRCSC, Ralph Gilbert, MD, FRCSC, Patrick J Gullane, MD, FRCSC, FACS, FRA, Dale H Brown, BSc, BCh, FRCSC, MB, Emma Barker, MD; University health network- Princess Margaret Cancer Centre

P047 (COSM Poster #097) PRESENTATION AND OUTCOME OF MELANOMA ARISING FROM THE MUCOUS MEMBRANES OF HEAD AND NECK IN COMPARISON TO OTHER MUCOSAL MELANOMAS AND CUTANEOUS MELANOMA: A SURVEILLANCE EPIDEMIOLOGY AND END RESULTS (SEER) DATABASE REVIEW Anteneh Tesfaye, MD, Ioana Morariu, MD, Radhika Kakarala, MD, David Eilender, MD, Sunil Nagpal, MD; McLaren Healthcare-Flint/ Michigan State University

P048 (COSM Poster #098) ASSESSMENT OF ORAL CAVITY AND LARYNGEAL CANCER QUALITY MEASURES IN A REGIONAL HEAD AND NECK TUMOR CLINIC Matthew G Yantis, MD, Peter Hunt, MD; University of Tennessee Health Science Center-Chattanooga

P049 (COSM Poster #099) RADIATION INDUCED SARCOMAS OF THE HEAD AND NECK Timothy S Wong, FRACDS, OMS, Colin Liew, MD, Nicholas Kalavrezos, Mr, Amrita Jay, Bagrat Lalabekyan, MD, Timothy Beale, MD, Simon Morley, MD, Phillip Pircoussis, FRACDS, OMS; University College London Hospital

P050 (COSM Poster #100) ANALYSIS OF READMISSIONS AFTER THYROIDECTOMY AND PARATHYROIDECTOMY ? DOES PPI THERAPY INCREASE RISK OF READMISSION SECONDARY TO POSTOPERATIVE HYPOCALCEMIA Narges Mazloom, DO, Tamer A Ghanem, MD, PhD, Francis T Hall, MD, Kathleen L Yaremchuk, MD; Department of Otolaryngology, Head and Neck Surgery, Henry Ford Hospital, Detroit, MI

P051 (COSM Poster #101) SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK OF UNKNOWN PRIMARY: A FIFTEEN-YEAR SINGLE INSTITUTION EXPERIENCE Leslie Kim, MD, MPH, Joshua Waltonen, MD, David E Schuller, MD, Enver Ozer, MD, Theodoros N Teknos, MD, Matthew O Old, MD, Ricardo Carrau, MD, Agrawal Amit, MD; The Ohio State University Wexner Medical Center

P052 (COSM Poster #102) IMPACT OF IRRADIATION OF INDEX HEAD AND NECK SQUAMOUS CELL CARCINOMA (HNSCC) ON DEVELOPMENT OF AND OUTCOME AFTER SECOND PRIMARY HNSCC. Alisa Zhukhovitskaya, Caitlin McMullen, MD, Richard V Smith, MD, Catherine Sarta, Bradley A Schiff, MD, Missak Haigentz, MD, Michael Prystowsky, MD, PhD, Nicolas F Schlecht, PhD, Thomas J Ow, MD; Montefiore Medical Center, Albert Einstein College of Medicine

P053 (COSM Poster #103) ACCURACY OF COMPUTED TOMOGRAPHY IN THE PREDICTION OF EXTRACAPSULAR SPREAD OF LYMPH NODE METASTASES IN SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK Raymond L Chai, MD, Tanya J Rath, MD, Jonas T Johnson, MD, Robert L Ferris, MD, PhD, Gregory J Kubicek, MD, Umamaheswar Duvvuri, MD, PhD, Barton F Branstetter, MD; University of Pittsburgh Medical Center

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P054 (COSM Poster #104) HEAD & NECK SYNOVIAL SARCOMA – 50 YEARS OF EXPERIENCE AT A TERTIARY MEDICAL CENTER Matthew G Crowson, Ian J Lalich, MD, Andrew L Folpe, MD, Joaquin J Garcia, MD, Daniel L Price, MD;The Mayo Clinic, Department of Otorhinolaryngology

P055 (COSM Poster #105) PREDICTORS OF SURVIVAL IN CARCINOMA EX PLEOMORPHIC ADENOMA: AN ANALYSIS OF 278 PATIENTS Michelle M Chen, BA, Sanziana A Roman, MD, Julie A Sosa, MD, MA, Benjamin L Judson, MD; Department of Surgery, Yale University School of Medicine, New Haven, CT

P056 (COSM Poster #106) SURGICAL TREATMENT TRENDS IN THE MANAGEMENT OF THICK MELANOMAS OF THE HEAD AND NECK: A US POPULATION-BASED STUDY. Marcus M Monroe, MD, Jeffrey N Myers, MD, PhD, Michael E Kupferman, MD; Department of Head and Neck Surgery, University of Texas MD Anderson Cancer Center

P057 (COSM Poster #107) CREATION OF A BUNDLED PAYMENT FOR HEAD AND NECK SURGERY Robert R Lorenz, MD; Cleveland Clinic

P058 (COSM Poster #108) CLINICOPATHOLOGIC PREDICTORS OF RECURRENCE AND OVERALL SURVIVAL IN ADENOID CYSTIC CARCINOMA OF THE HEAD AND NECK: A SINGLE INSTITUTIONAL EXPERIENCE AT A TERTIARY CARE CENTER Anna Marcinow, MD, Lai Wei, PhD, Enver Ozer, MD, Theodoros Teknos, MD, O H Iwenofu, MD;The Ohio State University

P059 (COSM Poster #109) PROSPECTIVE STUDY OF VENOUS THROMBOEMBOLISM IN HEAD AND NECK CANCER PATIENTS AFTER SURGERY: INTERIM ANALYSIS Daniel Clayburgh, MD, PhD, Will Stott, BS, Teresa Kochanowski, ANPC, Renee Park, MD, Kara Detwiller, MD, Paul Flint, MD, Joshua Schindler, MD, Peter Andersen, MD, Mark Wax, MD, Neil Gross, MD; Oregon Health and Science University

P060 (COSM Poster #110) PROGNOSTIC SIGNIFICANCE OF MEDULLARY BONE INVASION IN ALVEOLAR ORAL CAVITY CARCINOMA Pablo H Montero, MD, Purvi D Patel, MD, Andrew G Shuman, MD, Frank L Palmer, BA, Ian Ganly, MD, PhD, Jatin P Shah, MD, Snehal G Patel, MD; Head and Neck Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center

P061 (COSM Poster #111) A COMPARISON OF NOMOGRAMS VERSUS TNM STAGING IN OUTCOME PREDICTION FOR PATIENTS WITH ORAL CANCER Pablo H Montero, MD, Changhong Yu, MS, Frank L Palmer, BA, Purvi D Patel, MD, Andrew G Shuman, MD, Ian Ganly, MD, PhD, Jatin P Shah, MD, Michael W Kattan, PhD, Snehal G Patel, MD; 1 Head and Neck Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center. 2 Department of Quantitative Health Sciences, The Cleveland Clinic, Cleveland, Ohio

P062 (COSM Poster #112) IS POSTOPERATIVE RADIATION THERAPY INDICATED IN ALL ORAL CANCER PATIENTS WITH CLOSE MARGINS? Pablo H Montero, MD, Purvi D Patel, MD, Frank L Palmer, MD, Andrew G Shuman, MD, Snehal G Patel, MD, Nancy Y Lee, MD, Jatin P Shah, MD, Ian Ganly, MD, PhD; 1 Head and Neck Service, Department of Surgery; 2 Department of Radiation Oncology; Memorial Sloan-Kettering Cancer Center

P063 (COSM Poster #113) SHOULD TUMOR DEPTH MEASURED FROM AN INCISIONAL BIOPSY BE USED TO GUIDE THE DECISION TO PERFORM AN ELECTIVE NECK DISSECTION? Allen C Cheng, DDS, MD, M A Pogrel, DDS, MD, Brian L Schmidt, DDS, MD, PhD; University of California San Francisco, New York University

P064 (COSM Poster #114) CORRELATING THE PRESENCE OF HPV-16 IN THE ORAL MICROENVIRONMENT TO THE HISTOPATHOLOGIC GRADE OF ORAL CAVITY LESIONS Benjamin J Greene, MD, Vijay Jayaprakash, PhD, Kanitsak Boonantananasarn, DDS, PhD, Maureen Sullivan, DDS, Mihai Merzianu, MD, Saurin Popat, MD, Thom Loree, MD, Shawn D Newlands, MD, PhD, MBA, Steven Gill, PhD; University of Rochester School of Medicine and Dentistry and State University of New York at Buffalo School of Medicine and Biomedical Sciences

P065 (COSM Poster #115) ELECTIVE CERVICAL LYMPHADENECTOMY DURING SALVAGE SURGERY FOR LOCALLY RECURRENT HEAD AND NECK SQUAMOUS CELL CARCINOMA AFTER THERAPEUTIC NECK RADIATION Brandon L Prendes, MD, Annick Aubin-Pouliot, BS, Nitin Egbert, William R Ryan, MD; University of California, San Francisco

P066 (COSM Poster #116) HEAD AND NECK PARAGANGLIOMAS: A REVIEW OF 92 PATIENTS Theresa Tran, MD, Michael Persky, MD, Sophie Scherl, BA, Jason B Clair, BS, Jonathan Wallach, MD, Kenneth Hu, MD, Mark L Urken, MD, Adam S Jacobson, MD, Louis B Harrison, MD, Mark S Persky, MD; Head and Neck Institute at Beth Israel Medical Center, New York NY

P067 (COSM Poster #117) ORAL CAVITY CANCER IN PATIENTS UNDER 40 YEARS OF AGE Kyle Mannion, MD, Adam Luginbuhl, MD, Sarah Rohde, MD, Robert Sinard, MD, Kristin Stevens; Vanderbilt University Medical Center

P068 (COSM Poster #118) MEDICARE COST IMPLICATIONS IN TREATMENT OF T1-T3 LARYNGEAL CARCINOMA Ali Razfar, MD, Tristan Grogan, MS, Steve Lee, MD, David Elashoff, PhD, Elliot Abemayor, MD, PhD, Maie St. John, MD, PhD; UCLA Department of Head and Neck Surgery

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P069 (COSM Poster #119) DIVERGENT EFFECTS OF CHEMORADIOTHERAPY ON IMMUNOSUPPRESSIVE HOST CELL POPULATIONS, AND IMPLICATIONS FOR IMMUNOTHERAPY

Arjun Yerasi, Falguni Parikh, Amelia Clark, Manishkumar Patel, Rachel Abbott, Krzys Misiukiewicz, Marcello Bonomi, Vishal Gupta, Marshall Posner, Seunghye Kim-Schulze, [Andrew G Sikora](#); Mount Sinai School of Medicine

P070 (COSM Poster #120) SURGICAL MANAGEMENT OF OROPHARYNGEAL SQUAMOUS CELL CARCINOMA: SURVIVAL AND FUNCTIONAL OUTCOMES

Bhavna Kumar, MS, Michael Cipolla, MD, Nicole Arradaz, PhD, Peter Dziegielewski, md, Kasim Durmus, MD, Enver Ozer, md, Matthew Old, md, Amit Agrawal, md, Ricardo Carrau, md, David E Schuller, md, Marino Leon, md, Quintin Pan, phd, Pawan Kumar, phd, Valerie Wood, md, Jessica Burgers, md, Paul Wakely, md, [Theodoros N. Teknos](#), MD; The Ohio State University Medical Center, James Cancer Hospital and Solove Research Institute

P071 (COSM Poster #121) OUTPATIENT CHEMOTHERAPY WITH S-1 FOR UNRESECTABLE AND/OR DISTANT METASTATIC HEAD AND NECK CANCER

[Mayuka Maeda](#), MD, Taku Yamashita, MD, PhD, Takeshi Matsunobu, MD, PhD, Koji Araki, MD, PhD, Masayuki Tomifujii, MD, PhD, Akihiro Shiotani, MD, PhD; Department of Otolaryngology-Head and Neck Surgery, National Defense Medical College of Japan

P072 (COSM Poster #122) PREDICTIVE FACTORS FOR PROPHYLACTIC PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE PLACEMENT AND USE IN INTENSITY MODULATED RADIATION THERAPY (IMRT) TREATED HEAD AND NECK PATIENTS: CONCORDANCE, DISCREPANCIES AND THE ROLE OF GABAPENTIN

[Wuyang Yang](#), MD, MS, Sara Madanika, Rachit Kumar, MD, Heather Starmer, MS, Todd McNutt, PhD, Kimberly Evans, Nichole Mills, RN, BSN, Marian Richardson, MSN, Christine Gourin, MD, MPH, Susannah Ellsworth, MD, Nishant Agrawal, MD, Jeremy Richmond, MD, PhD, Young Kim Kim, MD, Christine Chung, MD, Wayne Koch, MD, Joe Califano, MD, David Eisele, MD, Harry Quon, MD, MS; Johns Hopkins School of Medicine

P073 (COSM Poster #123) PROPRANOLOL AS A PHARMACOTHERAPEUTIC AGENT IN THE TREATMENT OF ARTERIOVENOUS MALFORMATIONS: A PILOT STUDY

Bradley A Hobbs, MD, [James Y Suen](#), MD, Gresham T Richter, MD; University of Arkansas for Medical Sciences, Arkansas Children's Hospital, Department of Otolaryngology-Head

P074 (COSM Poster #124) COMPARATIVE STUDY BETWEEN TRANSORAL ROBOTIC SURGERY AND CONVENTIONAL SURGERY FOR TREATMENT OF SQUAMOUS CELL CARCINOMA OF THE UPPER AERODIGESTIVE TRACT

[Karim Hammoudi](#), MD, Eric Pinlong, MD, Soo Kim, MD, Patrice Beutter, PhD, Sylvain Moriniere, PhD; CHRU Bretonneau, TOURS, FRANCE

P075 (COSM Poster #125) HEAT GENERATION DURING ABLATION OF PORCINE SKIN WITH ER:YAG LASER VERSUS A NOVEL PICOSECOND INFRARED LASER (PIRL)

[Nathan Jowett](#), MD, FRCSC, Wolfgang Wöllmer, PhD, Alex M Mlynarek, MD, MSc, FRCSC, Paul Wiseman, PhD, Bernard Segal, PhD, Kresimir Franjic, PhD, Peter Krötz, MSc, Arne Böttcher, MD, Rainald Knecht, MD, PhD, RJ Dwayne Miller, PhD; Dept. of Otolaryngology - Head and Neck Surgery, McGill University and Dept. of Oto-, Rhino-, Laryngology, University Medical Centre Hamburg - Eppendorf

P076 (COSM Poster #126) EFFECT OF POLYGLYCOLIC ACID SHEETS AND FIBRIN GLUE ON WOUND HEALING AFTER PARTIAL RESECTION OF ORAL CANCER

[Morimasa Kitamura](#), MD, Ryo Asato, MD, Shigeru Hirano, MD, PhD, Ichiro Tateya, MD, PhD, Shinpei Kada, MD, PhD, Seiji Ishikawa, MD, Kuninobu Mizuta, MD, Nao Hiwatashi, MD, Juichi Ito, MD, PhD; Department of Otolaryngology, Head and Neck Surgery, Kyoto University

P077 (COSM Poster #127) THE ROLE OF ON-SITE CYTOTECHNOLOGIST ASSESSMENT FOR FNA OF SALIVARY GLAND MASSES AND NECK MASSES

Lamont Jones, MD, Tamer Ghanem, MD, [Matthew Smith](#), MD, Ziyang Zhang, MD, Catherine Lumley; Henry Ford Hospital

P078 (COSM Poster #128) TRANSORAL KTP ANGIOLYTIC LASER TREATMENT OF EARLY LARYNGEAL CANCER: A REPORT OF 62 PATIENTS

[Mark N Segal](#); Kaiser Permanente, SCPMG

P079 (COSM Poster #129) ASSESSING THE VALUE OF TRANSORAL ROBOTIC SURGERY VERSUS DEFINITIVE RADIOTHERAPY (WITH OR WITHOUT CHEMOTHERAPY) FOR EARLY T-STAGE OROPHARYNGEAL CANCER: A COST-UTILITY ANALYSIS

[John R de Almeida](#), MD, MSc, Alan Moskowitz, MD, Brett Miles, MD, DDS, Marita STeng, MD, Vishal Gupta, MD, Marshall Posner, MD, Eric M Genden, MD; Mount Sinai School of Medicine

P080 (COSM Poster #130) A MODULAR POLYMER PLATFORM SIGNIFICANTLY REDUCES THE REQUIRED DOSE OF XRT

[Maie St. John](#), MD, PhD, Yuan Lin, PhD, Jie Luo, MS, Matthew Lee, MD, Nopawan Vorasubin, MD, Ben Wu, DDS, PhD, David Elashoff, PhD, Elliot Abemayor, MD, PhD; University of California, Los Angeles

P081 (COSM Poster #131) INTERSTITIAL PHOTODYNAMIC THERAPY IN COMBINATION WITH CETUXIMAB FOR RECURRENT UNRESECTABLE HEAD AND NECK SQUAMOUS CELL CARCINOMA

Nestor Rigual, MD, [Gal Shafirstein](#), PhD; Roswell Park Cancer Institute

P082 (COSM Poster #132) TRANSFORMING HEAD AND NECK CLINICAL DATA COLLECTION WITH COMPUTER TABLET TECHNOLOGY

[Michael D Otremba](#), MD, Graeme M Rosenberg, BA, Wendell G Yarbrough, MD, Benjamin L Judson, MD; Yale University School of Medicine

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P083 (COSM Poster #133) NON-INVASIVE OPTICAL IMAGING MODALITIES AS A DIAGNOSTIC AID IN MANAGING PATIENTS WITH ORAL LEUKOPLAKIA

Vijayashree Bhattar, Ann M Gillenwater, MD, Rebecca Richards-Kortum, PhD, Sharon Mondrik, Richard Schwarz, PhD, Sohini Dhar, Mark Pierce, PhD, Jana Howe, Michelle D Williams, MD; University of Texas M.D. Anderson Cancer Center, Houston, Texas; Rice University, Dept. of Bioengineering, Houston, Texas

P084 (COSM Poster #134) APPLICATION OF SALIVARY STENTS IN ENDOSCOPIC MANAGEMENT OF SALIVARY GLAND DISORDERS: A PRELIMINARY EXPERIENCE Matthew A Bowen, MD, Rohan R Walvekar, MD; Louisiana State University Health Sciences Center - New Orleans

P085 (COSM Poster #135) USE OF ULTRASOUND BEFORE SIALENDOSCOPY DURING EVALUATION OF OBSTRUCTIVE PAROTID GLAND DISEASE Arjun Joshi, MD, Sean Hashemi, BS; The George Washington University - Division of Otolaryngology - Head and Neck Surgery

P086 (COSM Poster #136) USE OF ULTRASOUND BEFORE SIALENDOSCOPY DURING EVALUATION OF OBSTRUCTIVE SUBMANDIBULAR GLAND DISEASE Arjun Joshi, MD, Sean Hashemi, BS; The George Washington University - Division of Otolaryngology - Head and Neck Surgery

P087 (COSM Poster #137) CORNICULATE FLAP RECONSTRUCTION AFTER SUPRACRICOID PARTIAL LARYNGECTOMY Myriam Loyo, MD, Christopher Holsinger, MD, PhD, Ollivier Laccourreye, MD; Johns Hopkins, MD Anderson, and Université Paris Descartes Sorbonne

P088 (COSM Poster #138) LEVEL IIB LYMPH NODE METASTASIS IN ORAL CAVITY SQUAMOUS CELL CARCINOMA Brian C Gross, MD, Steven Olsen, MD, Jean E Lewis, MD, Daniel L Price, MD, Kerry D Olsen, MD; Mayo Clinic - Rochester, MN

P089 (COSM Poster #139) TREATMENT OUTCOMES OF ORGAN PRESERVATION STRATEGIES FOR LOCALLY ADVANCED LARYNGEAL CANCER BASED ON PROSPECTIVE MULTI-DISCIPLINARY TREATMENT PLANNING David W Timme, MD, Sashikanth Jonnalagodda, MD, Raunak Patel, BS, Krishna Rao, MD, PhD, KThomas Robbins, MD; Southern Illinois University School of Medicine

P090 (COSM Poster #140) ONCOLOGIC AND FUNCTIONAL OUTCOMES OF TRANSORAL ROBOTIC SURGERY FOR OROPHARYNGEAL CANCER Young Min Park, Won Shik Kim, Hyung Kwon Byeon, Eun Chang Choi, Se-Heon Kim; Yonsei University College of Medicine

P091 (COSM Poster #141) SURGICAL TECHNIQUES AND TREATMENT OUTCOMES OF TRANSORAL ROBOTIC SUPRAGLOTTIC PARTIAL LARYNGECTOMY Young Min Park, Won Shik Kim, Hyung Kwon Byeon, Eun Chang Choi, Se-Heon Kim; Yonsei University College of Medicine

P092 (COSM Poster #142) MANAGEMENT OF UNKNOWN PRIMARIES WITH TRANSORAL LASER MICROSURGERY AND NECK DISSECTION IN THE PRESENCE OF P16-POSITIVITY Evan M Graboyes, MD, Parul Sinha, MBBS, MS, Jason T Rich, MD, Bruce H Haughey, MBChB, FACS, FRACS; Washington University in Saint Louis

P093 (COSM Poster #143) THE IMPACT OF PARAGLOTTIC SPACE IN SUPRACRICOID PARTIAL LARYNGECTOMY Min Sik Kim, MD, PhD, Kwang Jae Cho, MD, PhD, Jun Ook Park, MD, In Chul Nam, MD, Chung Soo Kim, MD; The Catholic University of Korea

P094 (COSM Poster #144) ENDOSCOPE ASSISTED SUBMUCOSAL DISSECTION FOR EARLY PHARYNGEAL CANCER DETECTED BY NARROW BAND IMAGING TECHNOLOGY Ichiro Tateya, MD, PhD, Manabu Muto, MD, PhD, Shuko Morita, MD, Shin-ichi Miyamoto, MD, Shigeru Hirano, MD, PhD, Morimasa Kitamura, MD, Seiji Ishikawa, MD, Juichi Ito, MD, PhD; Kyoto University

P095 (COSM Poster #145) FUNCTIONAL OUTCOME, SURVIVAL, AND APPLICABILITY OF TRANSORAL LASER SURGERY IN A COMPLETE COHORT OF PATIENTS WITH SUPRAGLOTTIC SQUAMOUS CELL CARCINOMA. Graeme M Rosenberg, Stewart I Adam, MD, Michael D Otremba, MD, Clarence T Sasaki, MD, Benjamin L Judson, MD, MPA; Yale University School of Medicine

P096 (COSM Poster #146) A COMPARISON OF SURVIVAL AND FUNCTIONAL OUTCOMES IN ADVANCED STAGE BUT EARLY-T-STAGE OROPHARYNGEAL SQUAMOUS CELL CARCINOMA TREATED WITH TRANSORAL RESECTION OR CHEMORADIOTHERAPY Matthew J Ward, MRCS, Emma V King, PhD, FRCS, Gareth J Thomas, PhD, Christopher J Randall, FRCS, Christopher A Baughan, FRCR, Ram Shanmugasundaram, FRCR, Nimesh N Patel, MSc, FRCS; Cancer Sciences Unit, University of Southampton, UK. Department of ENT, Southampton General Hospital, UK. Department of Oncology, Southampton General Hospital, UK.

P097 (COSM Poster #147) INITIAL NEGATIVE MARGINS MAY BE ASSOCIATED WITH OVERALL SURVIVAL IN PATIENTS UNDERGOING TRANSORAL ROBOTIC SURGERY FOR HEAD AND NECK CANCER Alexandra E Kejner, MD, J. Scott Magnuson, MD, Eben L Rosenthal, MD, William R Carroll, MD; University of Alabama - Birmingham

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P098 (COSM Poster #148) EVALUATION OF SWALLOW AFTER SUPRACRICOID LARYNGECTOMY WITH CRICOHYOIDOEPYGLOTTOPEXY (SCL-CHEP) BY VIDEOFLUOROSCOPY Yutomo Seino, MD, PhD, Jacqui Allen, MD, FRACS, Meijin Nakayama, MD, PhD, Anna Miles, Makito Okamoto, MD, PhD; Department of Otorhinolaryngology Kitasato University School of Medicine/ North Shore Hospital/The University of Auckland

P099 (COSM Poster #149) MANAGEMENT OF UNTREATED GLOTTIC SQUAMOUS CELL CARCINOMA BY TRANSORAL LASER MICROSURGERY: ONCOLOGIC OUTCOMES, MANAGEMENT OF RECURRENCE, AND PROGNOSTIC FACTORS Andrew T Day, MD, Parul Sinha, MBBS, MS, Kallogjeri Dorina, MD, Brian Nussenbaum, MD, FACS, Bruce Haughey, MBChB, FACS, FRACS; Washington University School of Medicine

P100 (COSM Poster #150) PREDICTIVE NOMOGRAMS FOR SURVIVAL AFTER SURGICAL MANAGEMENT OF MALIGNANT TUMORS OF THE MAJOR SALIVARY GLANDS. Safina Ali, MD, Frank L Palmer, BA, Changhong Yu, MS, Monica Witcher, BA, Jatin P Shah, MD, Michael W Kattan*, PhD, Snehal G Patel, MD, Ian Ganly, MD, PhD; Memorial Sloan-Kettering Cancer Center, New York, *Department of Quantitative Health Sciences, The Cleveland Clinic, Ohio

P101 (COSM Poster #151) THE ROLE OF TRANSORAL ROBOTIC SURGERY IN THE WORK-UP OF THE UNKNOWN PRIMARY HEAD AND NECK SQUAMOUS CELL CARCINOMA Sapna A Patel, MD, J. Scott Magnuson, MD, F. Christopher Holsinger, MD, Ron J Karni, MD, Jay K Ferrell, MD, Jeremy D Richmon, Neil D Gross, MD, Eduardo Mendez, MD, MS; University of Washington Medical Center, M.D. Anderson Cancer Center, University of Alabama- Birmingham Hospital, University of Texas Medical School at Houston, Johns Hopkins Hospital and Oregon Health Sciences University

P102 (COSM Poster #152) RETROSPECTIVE ANALYSIS OF ADULT HEAD AND NECK SARCOMA: A SINGLE-CENTER EXPERIENCE FROM 2000-2012 Xiaoyu Chai, Amy E Chang, Kris S Moe, MD, Neal Futran, MD, Robin L Jones, MD; University of Washington School of Medicine

P103 (COSM Poster #153) LARYNGEAL CARCINOMA: COMPARING A SINGLE ACADEMIC TERTIARY HOSPITAL TO NATIONAL DATA Blake J LeBlanc, MD, Glenn Mills, MD, Runhua Shi, MD, PhD, Federico Ampil, MD, Cherie-Ann Nathan, MD; LSU Health - Shreveport

P104 (COSM Poster #154) MANAGEMENT OF LYMPHEDEMA IN PATIENTS WITH HEAD AND NECK CANCER Brad G Smith, MS, CLT, Katherine A Hutcheson, PhD, Roman J Skoracki, MD, Leila G Little, MS, CLT, David I Rosenthal, MD, Stephen Y Lai, MD, PhD, Jan S Lewin, PhD; The University of Texas MD Anderson Cancer Center

P105 (COSM Poster #155) ANALYSIS OF DISTANT FAILURE PATTERNS AND SECOND PRIMARY CANCERS IN PATIENTS TREATED WITH DEFINITIVE INTENSITY MODULATED RADIATION THERAPY (IMRT) FOR OROPHARYNGEAL SQUAMOUS CELL CARCINOMA (OPSCC) Edwin F Crandley, MD, David D Wilson, MD, Austin J Sim, Neil Majithia, Asal S Rahimi, MD, Edward B Stelow, MD, Mark J Jameson, MD, PhD, David S Shonka, MD, Paul W Read, MD, PhD; University of Virginia, University of Texas-Southwestern

P106 (COSM Poster #156) FUNCTION AFTER TORS FOR OROPHARYNGEAL CANCER: A SYSTEMATIC REVIEW Katherine A Hutcheson, PhD, F. Christopher Holsinger, MD, Michael E Kupferman, MD, Jan S Lewin, PhD; The University of Texas MD Anderson Cancer Center

P107 (COSM Poster #157) THE USE OF INPATIENT PALLIATIVE CARE SERVICES IN PATIENTS WITH METASTATIC INCURABLE HEAD AND NECK CANCER Christine G Gourin, MD, MPH, Thomas J Smith, MD, Sydney M Dy, MD, MPH; Johns Hopkins University and Johns Hopkins Bloomberg School of Public Health

P108 (COSM Poster #158) IMPROVING TIME FROM FIRST CONTACT TO INITIAL APPOINTMENT FOR HEAD AND NECK CANCER PATIENTS Carol M Lewis, MD, MPH, Jeremy Meade, MS, Judy Moore, RN, MSN, Sheila Harris, RN, MBA, Pheba Philip, BS, LaToya Spears, BS, Hettie Hebert, RN, Amy C Hessel, MD, Ehab Y Hanna, MD, Randal S Weber, MD; University of Texas MD Anderson Cancer Center

P109 (COSM Poster #159) DISPARITIES IN SURVIVAL FOR AMERICAN INDIANS WITH HEAD AND NECK SQUAMOUS CELL CARCINOMA Sunshine Dwojak, MD, MPH, Thomas D Sequist, MD, MPH, Kevin Emerick, MD, John Lee, MD, Daniel Peterreit, MD, Daniel G Deschler, MD; Massachusetts Eye and Ear Infirmary, Harvard Medical School, Division of General Medicine, Brigham and Women's Hospital, Sanford Cancer Research Center, John T. Vucurevich Cancer Care Institute at Rapid City Regional Hospital

P110 (COSM Poster #160) COMPARATIVE EFFECTIVENESS OF SURGICAL AND NON-SURGICAL THERAPY FOR ADVANCED LARYNGEAL CANCER: A SEER-MEDICARE STUDY 1997-2007 Kara K Prickett, MD, Chun Chieh Lin, PhD, Amy Y Chen, MD, MPH; Emory University Department of Otolaryngology, American Cancer Society

P111 (COSM Poster #161) THE EFFECT OF MARRIAGE ON OUTCOMES FOR HEAD AND NECK CANCER Christopher S Hollenbeak, PhD, Eric W Schaefer, MS, David Goldenberg, MD, Heath Mackley, MD, Wayne Koch, MD; Penn State College of Medicine; Johns Hopkins University

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P112 (COSM Poster #162) INCIDENCE AND RISK FACTORS OF SURGICAL COMPLICATIONS IN ORAL CAVITY CANCER

Pablo H Montero, MD, Claudia R Albornoz, Andrew G Shuman, MD, Frank L Palmer, MD, Ian Ganly, MD, PhD, Jatin P Shah, MD, Snehal G Patel, MD; Head and Neck Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center

P113 (COSM Poster #163) THE PROGNOSTIC SIGNIFICANCE OF EXTRACAPSULAR SPREAD IN HPV-ASSOCIATED OROPHARYNGEAL SQUAMOUS CELL CARCINOMA

Brieze R Keeley, BA, Eitan Prisman, MD, Nathaniel L Villanueva, BS, Erden Goljo, BS, Eric Genden, MD, Andrew G Sikora, MD, PhD; The Mount Sinai School of Medicine, Department of Otolaryngology, Immunology Institute

P114 (COSM Poster #164) WHAT VARIABLES PREDICT TRACHEOSTOMY OR GASTROSTOMY PLACEMENT IN OROPHARYNGEAL CANCER PATIENTS UNDERGOING TORS?

Eitan Prisman, MD, Brieze R Keeley, BA, Erden Goljo, BS, Brett Miles, MD, DDS, Andrew G Sikora, MD, PhD, Eric M Genden, MD; The Mount Sinai School of Medicine, Department of Otolaryngology

P115 (COSM Poster #165) IS PERSISTENT PET/CT SURVEILLANCE USEFUL IN HPV-ASSOCIATED HEAD AND NECK SQUAMOUS CELL CARCINOMA?

Yekaterina Koshkareva, MD, Barton F Branstetter IV, MD, William E Gooding, MS, Robert L Ferris, MD, PhD; University of Pittsburgh Medical Center

P116 (COSM Poster #166) EXTRACAPSULAR NODAL SPREAD DOES NOT PREDICT OUTCOME IN CLINICALLY NODE NEGATIVE ORAL CAVITY SQUAMOUS CELL CARCINOMA

Volkert B Wreesmann, MD, PhD, Ronald A Ghossein, MD, Diane Carlson, MD, Ian Ganly, MD, Frank Palmer, MSc, Pablo Montero, MD, Jatin Shah, MD, Snehal Patel, MD; Memorial Sloan-Kettering Cancer Center

P117 (COSM Poster #167) HEAD AND NECK CANCER MULTIDISCIPLINARY CONFERENCE: IMPROVING PATIENT OUTCOMES

Carol M Lewis, MD, MPH, Zhannat Nurgalieva, PhD, Erich M Sturgis, MD, MPH, Stephen Y Lai, MD, PhD, Beth M Beadle, MD, PhD, William N William, MD, Randal S Weber, MD; University of Texas MD Anderson Cancer Center

P118 (COSM Poster #168) THE USE OF GIA STAPLER FOR STERNOCLEIDOMASTOID MUSCLE FLAP IN PAROTIDECTOMY DEFECT RECONSTRUCTION

Neil Gildener-Leapman, MD, Kashif Mazhar, MD, James Attra, MD, Dale Rice, MD; University of Southern California, University of Pittsburgh Medical Center

P119 (COSM Poster #169) INTRALUMINAL NEGATIVE PRESSURE WOUND THERAPY FOR OPTIMIZING PHARYNGEAL RECONSTRUCTION

Scott A Asher, MD, Hilliary N White, MD, Elisa A Illing, MD, William R Carroll, MD, J S Magnuson, MD, Eben L Rosenthal, MD; The University of Alabama at Birmingham

P120 (COSM Poster #170) FUNCTIONAL OUTCOMES OF SCAPULAR ANGLE OSTEOMUSCULAR FLAP IN POSTMAXILLECTOMY RECONSTRUCTION

Cesare Piazza, MD, Francesca Del Bon, MD, Valentina Taglietti, MD, Alberto Paderno, MD, Piero Nicolai, Professor; Department of Otorhinolaryngology ? Head and Neck Surgery, University of Brescia, Italy

P121 (COSM Poster #171) USE OF INTEGRA DERMAL REGENERATION TEMPLATE AS AN ALTERNATIVE TOOL IN COMPLEX HEAD RECONSTRUCTION.

Fedele Lembo, MD, Domenico Parisi, MD, Aurelio Portincasa, MD, FEBOPRAS; Plastic and Reconstructive Surgery Department - University of Foggia

P122 (COSM Poster #172) THE STAIRCASE TECHNIQUE: A RATIONAL APPROACH TO LOWER LIP RECONSTRUCTION

Fedele Lembo, MD, Domenico Parisi, MD, Aurelio Portincasa, MD, FEBOPRAS; Plastic and Reconstructive Surgery Department - University of Foggia

P123 (COSM Poster #173) ZITELLI FLAP AN VALUABLE OPTION FOR NOSE RECONSTRUCTION

Fedele Lembo, MD, Domenico Parisi, MD, Aurelio Portincasa, MD, FEBOPRAS; Plastic and Reconstructive Surgery Department - University of Foggia

P124 (COSM Poster #174) SEGMENTAL MANDIBULECTOMY AND MICROVASCULAR FREE FLAP RECONSTRUCTION FOLLOWING BISPHTHOSONATE-RELATED OSTEONECROSIS OF THE JAWS: CASE SERIES

Matthew M Hanasono, MD, Oleg N Milisakh, MD, Jeremy D Richmon, MD, Eben L Rosenthal, MD, Mark K Wax, MD; MD Anderson Cancer, University of Nebraska, Johns Hopkins University, University of Alabama, and Oregon Health Sciences University

P125 (COSM Poster #175) OUTCOMES IN RECONSTRUCTION AFTER PHARYNGECTOMY: RADIAL FOREARM VS ANTEROLATERAL THIGH FREE FLAPS

Michael R Kinzinger, BA, Chad Zender, MD, Rod Rezaee, MD; University Hospitals Case Medical Center, Case Western Reserve University School of Medicine

P126 (COSM Poster #176) CRANIOFACIAL BONE RECONSTRUCTION WITH A NOVEL BIOACTIVE COMPOSITE IMPLANT

Kalle J Aitasalo, Professor, Jaakko M Piitulainen, MD, Jami Rekola, PhD; 1. Department of Otorhinolaryngology - Head and Neck Surgery, Turku University Hospital 2. Biomaterials Research, Institute of Dentistry and Biomaterials Science, University of Turku, Turku Finland.

P127 (COSM Poster #177) OUTCOMES OF FASCIO-CUTANEOUS FREE FLAPS FOR HYPOPHARYNGEAL WITH OR WITHOUT CERVICAL ESOPHAGEAL DEFECTS RECONSTRUCTION

Cesare Piazza, MD, Francesca Del Bon, MD, Valentina Taglietti, MD, Piero Nicolai, Professor; Department of Otorhinolaryngology - Head and Neck Surgery, University of Brescia, Italy

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P128 (COSM Poster #178) COMPLICATIONS AND FUNCTIONAL OUTCOMES AFTER PHARYNGOESOPHAGEAL DEFECT RECONSTRUCTION: A COMPARISON OF PEDICLED REGIONAL FLAPS VS. FREE TISSUE TRANSFER Lucia S Olarte, MD, Rajan Dang, BA, Jamie Pak, BA, Joshua Rosenberg, MD; Mount Sinai School of Medicine

P129 (COSM Poster #179) COMPARISON OF SKIN GRAFT DONOR SITES FOR FIBULA FREE FLAP SKIN PADDE RECONSTRUCTION Tyler P Litton, Jacob L Wester, Neil D Gross, MD, FACS, Amy L Pittman, MD, Mark K Wax, MD, FACS, FRCS; New York University School of Medicine, New York, New York. Department of Otolaryngology, Oregon Health and Science University, Portland, Oregon.

P130 (COSM Poster #180) MICROVASCULAR HEAD AND NECK RECONSTRUCTION IN THE PACIFIC ISLAND HEALTH CARE PROJECT: EXPERIENCE THAT TRANSLATES TO OPTIMAL CARE FOR COMBAT WOUNDED Kelly G Groom, MD, Christopher Klem, MD; Tripler Army Medical Center

P131 (COSM Poster #181) COMPARATIVE STUDY OF FREE FLAP RECONSTRUCTION AFTER ROBOT-ASSISTED NECK DISSECTION VERSUS CONVENTIONAL NECK DISSECTION IN ORAL CAVITY AND OROPHARYNGEAL CANCER Young Min Park, MD, Won Jai Lee, MD, Dong Won Lee, MD, In Sik Yoon, MD, Dae Hyun Lew, MD, PhD, Won Shik Kim, MD, Yoon Woo Koh, MD, PhD, Eun Chang Choi, MD, PhD; 1Department of Otorhinolaryngology, Yonsei University College of Medicine, Seoul, Korea 2Department of Plastic and Reconstructive Surgery, Yonsei University College of Medicine, Seoul, Korea

P132 (COSM Poster #182) DISTRIBUTION OF EPSTEIN-BARR VIRAL LOAD IN SERUM OF PATIENTS WITH NASOPHARYNGEAL CARCINOMA AND HIGH-RISK FAMILIES IN SINGAPORE. Joshua K Tay, MBBS, MRCS, MMed, Soh Ha Chan, MBBS, FRCPA, PhD, Chwee Ming Lim, MBBS, MRCS, MMed, Thomas Loh, MBBS, FRCS; National University Health System, Singapore

P133 (COSM Poster #183) EVALUATION OF UTILIZATION OF HEALTH WORKERS AND REMOTE DIAGNOSIS IN A MOBILE BASED ORAL CANCER SCREENING IN INDIA Praveen Birur, MDS, Rani Desai, MA, Ashifur Rahman, BDS, Chetan Mukundan, BE, Moni Abraham Kuriakose, FDSRCS; Biocon Foundation

P134 (COSM Poster #184) OUTCOMES OF A HEAD AND NECK CANCER SCREENING CLINIC Andrew G Shuman, MD, Prateek Patel, Dorothy Thomas, BA, Frank Palmer, BA, Brian T Shaffer, MD, Janet T McKiernan, RN, MS, OCN, Jatin P Shah, MD, FACS, Snehal G Patel, MD, FRCS, Jay O Boyle, MD; Memorial Sloan-Kettering Cancer Center

P135 (COSM Poster #185) SOCIOECONOMIC FACTORS IMPACT STAGE AT PRESENTATION IN HNSCC PATIENTS Julianna Pesce, MD, Abie H Mendelsohn, MD, Yas Sanaiha, Elliot Abemayor, MD, PhD, Maie St. John, MD, PhD; Division of Head and Neck Surgery, University of California, Los Angeles

P136 (COSM Poster #186) RISK OF SECOND PRIMARY MALIGNANCY IN SURVIVORS OF RETINOBLASTOMA Kunal S Jain, MD, Andrew G Sikora, MD, PhD, Jeffrey C Liu, MD, Luc G Morris, MD; Memorial Sloan-Kettering Cancer Center, SUNY Upstate Medical University, Mount Sinai School of Medicine, Temple University School of Medicine

P137 (COSM Poster #187) HEAD AND NECK SQUAMOUS CELL CARCINOMA AND DISPARITIES: A MODEL FOR EARLY DETECTION Lutecia H Pereira, PhD, Isildinha Reis, PhD, Robert Duncan, PhD, Erika P Reategui, MS, Claudia Gordon, BS, Laurian Walters, BS, Aymee Perez, PhD, Elizabeth J Franzmann, MD; University of Miami Miller School of Medicine

P138 (COSM Poster #188) AN INVESTIGATION OF THE EFFECTIVENESS OF MOLECULAR ASSAYS Eliza Kostas-Polston, PhD, APRN, WHNPBC, Mark Varvares, MD; University of South Florida

P139 (COSM Poster #189) RECURRENT PAPILLARY THYROID CANCER OF THE SPHENOID WING, ORBIT AND INFRATEMPORAL FOSSA Elliott Kozin, MD, Gillian Diercks, MD, Josef Shargorodsky, MD, Alice Lin, MD, Frederick Barker, MD, Derrick Lin, MD; Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, Harvard Medical School

P140 (COSM Poster #190) ANALYSIS OF THE DISTINGUISHING HISTOLOGICAL AND IMMUNOHISTOCHEMICAL CHARACTERISTICS OF CHONDROID CHORDOMA, CHONDROSARCOMA AND CLASSIC CHORDOMA OF THE CLIVUS Andrew M Terrell, MD, Christopher H Rassekh, MD, Jeffery P Hogg, MD, Charles L Rosen, MD, PhD, Barbara S Ducatman, MD; West Virginia University and University of Pennsylvania

P141 (COSM Poster #191) PROSPECTIVE STUDY OF HEAD AND NECK QUALITY OF LIFE IN A COMPREHENSIVE SKULL BASE SURGICAL PRACTICE Emily E Cohn, BSPH, Stephen A Wheless, MD, Kibwei A McKinney, MD, Robert J Taylor, BS, Adam M Zanation, MD; Department of Otolaryngology/Head and Neck Surgery, University of North Carolina Hospitals, Chapel Hill, NC 27514, USA; Department of Otolaryngology, University of Vermont Hospitals, Burlington, VT, USA

P142 (COSM Poster #192) PATTERNS OF CARE FOR WELL-DIFFERENTIATED THYROID CANCER Harry M Baddour, MD, Stacey A Fedewa, PhD, MPH, Amy Y Chen, MD, MPH, FACS; Department of Otolaryngology-Head and Neck Surgery, Emory University School of Medicine, Atlanta, GA, USA; American Cancer Society, Atlanta, GA, USA

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P143 (COSM Poster #193) PREDICTIVE VALUE OF STIMULATED POSTOPERATIVE THYROGLOBULIN LEVELS IN PATIENTS WITH DIFFERENTIATED THYROID CARCINOMA

Chih H Chen-Ku, MD, FACE, Efrain Cambrero, MD; Hospital San Juan de Dios, Instituto Costarricense de Oncologia

P144 (COSM Poster #194) LOCAL-REGIONAL FAILURE IN LOCALLY ADVANCED DIFFERENTIATED THYROID CANCER AFTER SURGERY AND RADIOACTIVE IODINE THERAPY

Adam Willson, BS, Mark Weissler, MD, David Fried, BS, Yeh Jin Jin, MD, Arif Sheikh, MD, Benjamin Calvo, MD, Carol Shores, MD, William Shockley, MD, Trevor Hackman, MD, Adam Zanation, MD, Bhisamjit Chera, MD; Department of Radiation Oncology, Department of Otolaryngology/Head & Neck Surgery, Department of Surgical Oncology, Lineberger Comprehensive Cancer Center, University of North Carolina Hospitals, Chapel Hill, NC

P145 (COSM Poster #195)

COMPARISON OF PATIENT AND TUMOR CHARACTERISTICS OF INCIDENTALLY-DISCOVERED THYROID CANCERS AND CLINICALLY-EVIDENT THYROID CANCERS

Frederick Yoo, BA, Irina Chaikoudtinov, MD, Jason Liao, PhD, David Goldenberg, MD, FACS; Department of Surgery, Division of Otolaryngology - Head and Neck Surgery, Pennsylvania State University - Milton S. Hershey Medical Center

P146 (COSM Poster #196) RISK FACTORS ASSOCIATED WITH PERIOPERATIVE AIRWAY COMPLICATIONS AMONG PATIENTS UNDERGOING SURGERY FOR MULTINODULAR GOITER

Patricia A Loftus, MD, Bianca Siegel, MD, Tj Ow, MD, Andrew Tassler, MD, Richard Smith, MD, Bradley Schiff, MD; Albert Einstein College of Medicine/ Montefiore Medical Center

P147 (COSM Poster #197) PRESERVATION OF INFERIOR THYROIDAL VEIN PREVENTS POST-THYROIDECTOMY HYPOCALCEMIA

Doh Young Lee, MD, Wonjae Cha, MD, Woo-jin Jeong, MD, PhD, Myung-Whun Sung, MD, PhD, Kwang Hyun Kim, MD, PhD, Soon-hyun Ahn, MD, PhD; Department of Otorhinolaryngology, Seoul National University Hospital

P148 (COSM Poster #198) RISK OF MELANOMA IS INCREASED IN INDIVIDUALS WITH PAPILLARY THYROID CARCINOMA

Gretchen M Oakley, MD, Karen Curtin, PhD, Lester J Layfield, MD, Elke A Jarboe, MD, Luke O Buchmann, MD, Jason P Hunt, MD; University of Utah Health Sciences Center

P149 (COSM Poster #199) SELECTIVE INDICATION OF PROPHYLACTIC CENTRAL NECK DISSECTION IN PAPILLARY THYROID CANCER

Andre Y De Carvalho, MD, Thiago C Chulam, MD, Wladyr B Fernandes Junior, MD, Luiz P Kowalski, MD; AC CAMARGO HOSPITAL

P150 (COSM Poster #200) COMPARISON OF MINIMAL ACCESS PARATHYROIDECTOMY WITH INTRA-OPERATIVE PTH DETERMINATION VERSUS STANDARD FOUR GLAND EXPLORATION

Matthew J Magarey, Jeremy L Freeman; Mt. Sinai Hospital, Toronto

P151 (COSM Poster #201) IS INTRAOPERATIVE PTH JUSTIFIED IN ALL PATIENTS UNDERGOING PARATHYROIDECTOMY?

Faisal Zawawi, MD, Alex M Mlynarek, MD, Arielle Cantor, Rickul Varshney, MD, Michael Hier, MD, Martin Black, MD, Richard J Payne, MD; McGill University

P152 (COSM Poster #202) IMPLICATIONS OF MULTIPLE LOCALIZATION STUDIES IN PRIMARY HYPERPARATHYROIDISM

Russell B Smith, MD, Maria Evasovich, MD, Gerry F Funk, MD, Douglas A Girod, MD, John H Lee, MD, Daniel D Lydiatt, MD, DDS, Robert P Zitsch, MD; Midwest Head and Neck Cancer Consortium

P153 (COSM Poster #203) PAPILLARY THYROID CARCINOMA IN THYROGLOSSAL DUCT CYSTS: AN ANALYSIS OF TREATMENT REGIMENS AND OUTCOMES

Aimee A Kennedy, BS, Alexander Gelbard, MD, Vlad C Sandulache, MD, Robert B Parke, MD, MBA; Baylor College of Medicine

P154 (COSM Poster #204) BRAF MUTATION IN PAPILLARY THYROID CARCINOMA: THE UNIVERSITY OF CALIFORNIA, SAN FRANCISCO EXPERIENCE

Christopher J Gouveia, MD, Nhu Thuy T Can, MD, Alan Bostrom, PhD, James P Grenert, MD, PhD, Annemieke van Zante, MD, PhD, Lisa A Orloff, MD; Northwestern University, University of California, San Francisco

P155 (COSM Poster #205) IMMUNOHISTOCHEMISTRY IS HIGHLY SENSITIVE AND SPECIFIC FOR THE DETECTION OF BRAF V600E MUTATION IN THYROID CANCER

Aron Pollack, MD, Jonathan Zagzag, MD, Linda A Dultz, MD, Shuman Dhar, BA, Jennifer B Ogilvie, MD, Keith S Heller, MD, Fang-Ming Deng, MD, PhD, Keval N Patel, MD; Department of Otolaryngology-Head and Neck Surgery, New York University Langone Medical Center

P156 (COSM Poster #206) OPTIMAL TIMING FOR A REPEAT THYROID BIOPSY

Ramsy Abdelghani, MD, Salem I Noureldine, MD, Ali Abbas, MD, MPH, Rizwan Aslam, DO, FACS, Paul Friedlander, MD, FACS, Emad Kandil, MD, FACS; Tulane University School of Medicine

P157 (COSM Poster #207) ENLARGED CERVICAL LYMPH NODES INCREASE THE PREDICTIVE VALUE IN DIAGNOSING PAPILLARY THYROID CARCINOMA IN SUSPICIOUS THYROID NODULES

Ramsy Abdelghani, MD, Ali Abbas, MD, MPH, Rizwan Aslam, DO, FACS, Paul Friedlander, MD, FACS, Emad Kandil, MD, FACS; Tulane University School of Medicine

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P158 (COSM Poster #259) AN EXPERIMENTAL APPROACH TO DEFINE FUNCTIONAL KINOMICS AND DRUGGABLE TARGETS IN ORAL SQUAMOUS CELL CARCINOMA USING PATHWAY-SPECIFIC INHIBITORS: IDENTIFICATION OF POLO-LIKE KINASE (PLK) ACTIVITY AND TARGET MODULATION IN CAL-27 CELLS

Wei Zhang, Pinaki Bose, PhD, Nigel T Brockton, Joseph C Dort, MD, [Aru Narendran, MD, PhD](#)

P 159 (COSM Poster #260) METFORMIN USE INCREASES SURVIVAL IN PATIENTS WITH LARYNGEAL SQUAMOUS CELL CARCINOMA

[John S Hamblin, Vlad C Sandulache, MD, PhD, Heath D Skinner, MD, PhD, Mark W Kubik, Jose P Zevallos, MD](#)

P160 (COSM Poster #261) FALSE NEGATIVE FINE NEEDLE ASPIRATION CYTOLOGY IN PAROTID MALIGNANCY

[Marianne Abouyared, Christopher E Fundakowski, MD, Johnathan Castano, MD, Andrew Rivera, MD, Rosemary Ojo, MD, Zoukaa Sargi, MD](#)

P161 (COSM Poster #262) ELECTIVE NECK DISSECTION FOR NO NECK DURING SALVAGE TOTAL LARYNGECTOMY: FINDINGS, COMPLICATIONS, AND ONCOLOGICAL OUTCOME

[Naveed Basheeth, Gerard O'Leary, Patrick Sheahan](#)

P162 (COSM Poster #263) FEASIBILITY AND RELEVANCE OF LEVEL I SUBSTATION NODE COUNTS IN NECK DISSECTIONS FOR OROPHARYGEAL CARCINOMA

[Christopher H Rassekh, MD, Bert W. O'Malley, Jr, MD, Arnaud F. Bewley, MD, Kathleen T. Montone, MD, Virginia A. Livolsi, MD, Gregory S. Weinstein, MD](#)

P163 (COSM Poster #264) SECONDARY TEP PLACEMENT IN-OFFICE USING SELDINGER TECHNIQUE: CASE SERIES

[Christopher J Britt, MD, Gregory K Hartig, MD, Dylan C Lippert, MD, Christopher J Britt, MD](#)

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[Demetri Arnaoutakis, BA, Joseph Califano, MD](#)

P165 (COSM Poster #266) DEVELOPMENT OF AN OBJECTIVE TRAINING CURRICULUM FOR TRANSORAL ROBOTIC SURGERY (TORS) AND ITS APPLICATION TO RESIDENT SURGICAL TRAINING

[Ryan H Sobel, MD, Patrick K Ha, MD, Joseph A Califano, MD, Ray G Blanco, MD, Gyusung Lee, PhD, Jeremy Richmon, MD](#)

P166 (COSM Poster #267) COMIC BOOKS, GRAPHIC NOVELS, AND THE NOVEL APPROACH TO TEACHING HEAD AND NECK SURGERY THROUGH THE GENRE OF THE COMIC BOOK

[Aa Chalian, Cs Babaian](#)

P167 (COSM Poster #268) FUNCTIONAL ASSESSMENT AFTER TOTAL OR SUBTOTAL GLOSSECTOMY AMONG PATIENTS WITH LOCALLY ADVANCED ORAL TONGUE SQUAMOUS CARCINOMA

[Katherine A Hutcheson, PhD, Hong Ju Park, PhD, Thomas J Ow, MD, Curtis R Pickering, PhD, Dianna Roberts, PhD, Mark S Chambers, DMD, MS, Jan S Lewin, PhD, Jeffrey N Myers, MD, PhD](#)

P168 (COSM Poster #269) PREOPERATIVE CHEMORADIATION IN MICROVASCULAR FREE FLAP RECONSTRUCTION: WHAT IS THE RISK?

[Isaac E Schwartz, Rod P Rezaee, MD, FACS, Chad A Zender, MD, FACS](#)

P169 (COSM Poster #270) HOW RELIABLE ARE THYROID NODULE FNA RESULTS IN THE PEDIATRIC POPULATION? A SYSTEMATIC REVIEW

[Celeste Gary, MD, Rohan Walvekar, MD](#)

AHNS 2013 New Members

The AHNS extends a warm welcome to the following new members.

Active

Mouwafak Al-Rawi
Akash Anand
Genevieve Andrews
Rizwan Aslam
Mihir Bhayani
Jennifer Bocker
James Bonner
Andrew Cowan
Carole Fakhry
Mark Furin
Tamer Ghanem
Avik Kumar Jana
Mumtaz Khan
Paul Konowitz
Teresa Kroeker
Steve Lee
Jason Leibowitz
David Lesnik
Kyle Mannion
Becky Massey
Vikas Mehta
Zvonimir Milas
Brett Miles
Nadia Mohyuddin
Luc Morris
Melonie Nance
Thomas Ow
Benjamin Saltman
Joshua Scolnick
David Shonka
Catherine Sinclair
Clementino Solares
William Spanos
Nilesh Vasani
Hilliary White
Francis Worden
Mark Zafereo
José Zevallos

Associate

Gideon Bachar
Steven Evelhoch
Basem Jamal
Cathy Lazarus
Virginia LiVolsi
Scott McLean
Mauricio Moreno
Jacques Nör
Gal Shafirstein

Candidate

Safina Ali
Hussain Alsaifar
Richard Bakst
Natalya Chernichenko
Alessandro Cusano
Louise Davies
Robert DeFatta
William Duke
Neerav Goyal
Allen Ho
Russel Kahmke
Frank Leusink
David Ludlow
Wojciech Mydlarz
Grace Nimmons
Ryan Orosco
Douglas Ruhl
Marika Russell
William Ryan
Steven Sperry
Jeremiah Tracy
Scott Troob
Kevin Wang
Vivian Wu
Geoffrey Young

Corresponding

Salma Al Sheibani
Christoph Bergmann
Andrés Chala
Jean-Pierre Jeannon
Masahiro Kikuchi
Ichiro Ota
Vinidh Paleri
Sandro Porceddu
KyungTae
Aigo Yamasaki
Seiichi Yoshimoto
Bin Zhang

Certificate of Incorporation

Certificate of Incorporation of The American Head and Neck Society, Inc.

Under Section 803 of the Not-for-Profit Corporation Law

1. The name of the Corporation is THE AMERICAN HEAD AND NECK SOCIETY, INC.
2. This Corporation has not been formed for pecuniary profit or financial gain, and shall not be conducted or operated for profit, and no part of the assets, income or net earnings of the Corporation is distributable or shall inure to the benefit of the directors, officers, or other private persons, except to the extent permitted under the Not-for-Profit Corporation Law. Upon the dissolution of this Corporation, no director, officer, or other private person shall be entitled to any distribution or division of its remaining property or its proceeds, and the balance of all money and property of the Corporation shall pass to, or shall inure to the benefit of, those organizations described in Section 201 of the Not-for-Profit Corporation Law and Section 501(c)(3) of the Internal Revenue Code of 1986, which are not private foundations described in Section 509(a) of such Code. Any such assets not so disposed of shall be disposed of by the Supreme Court of the State of New York for the County in which the principal office of the Corporation is then located, as provided by law, exclusively for such purposes or to such organization or organizations as said Court shall determine, which are organized and operated for the purposes set forth in Paragraph "3" below.
3. The purposes for which the Corporation is formed and the powers which may be exercised by the Corporation, in addition to the general powers set forth in Section 202 of the Not-for-Profit Corporation Law of the State of New York, are:
 - (a) to advance knowledge relevant to medical and surgical control of neoplasms of the head and neck;
 - (b) to solicit, obtain, apply for, and spend funds in furtherance of any activities or purposes of the Corporation;
 - (c) in general, to do any and all acts or things and to exercise any and all powers which may now or hereafter be lawful for the Corporation to do or exercise under and pursuant to the laws of the State of New York for the purpose of accomplishing any other purpose of the Corporation as set forth herein;
 - (d) to engage in any and all lawful activities incidental to any of the foregoing purposes of the Corporation.
4. The Corporation is organized exclusively to achieve public objectives, including for such purposes, the making of distributions to organizations that qualify as exempt organizations described in Section 115 or Section 501(c)(3) of the Internal Revenue Code of 1986, provided that such organizations are not private foundations described in Section 509(a) of such Code. The Corporation shall not carry on any other activities not permitted to be carried out by a corporation exempt from federal income tax under Section 501(c)(3) of such Code or by a corporation contributions to which are deductible under Section 170(c)(2) of such Code (or the corresponding provisions of any future United States Internal Revenue Law.)

Certificate of Incorporation

5. Nothing contained herein shall authorize this corporation to undertake or to carry out any of the activities specified in paragraphs (b) through (u) of Section 404 of the Not-for-Profit Corporation Law, or to establish, maintain or operate a hospital or to provide hospital service or health-related service, a certified home health agency, a hospice, a health maintenance organization, or a comprehensive health services plan, as provided for by Article 28, 36, 40 and 44, respectively, of the Public Health Law or to solicit, collect or otherwise raise or obtain any funds, contributions or grants from any source, for the establishment, maintenance or operation of any hospital or to engage in the practice of medicine or any other profession required to be licensed by Title VIII of the Education Law.
6. No substantial part of the activities of this Corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publication or distribution of statements), any political campaign on behalf of any candidate for public office.
7. The Corporation is a corporation as defined in subparagraph (a)(5) of Section 102 of the Not-for-Profit Corporation Law, and it is a Type B Corporation.
8. The territory in which the Corporation's activities are principally to be located is the territorial limits of the United States of America, the Domain of Canada and the Pan-American countries.
9. The number and manner of election or appointment of the directors constituting the Board of Directors shall be as provided in the Bylaws, except that the number of said Board members shall not be less than three (3). Members of the Board of Directors need not be residents of the State of New York. The names and addresses of the Directors of the Corporation who shall act until the first meeting of the Board of Directors, all of whom are over the age of eighteen (18) and are citizens of the United States, are:

<u>Names</u>	<u>Addresses</u>
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[Names and Addresses omitted.]
10. Management of the business and affairs of the Corporation is vested in the Board of Directors which shall use its best efforts to carry out in good faith the purposes of the Corporation.
11. To further the Corporation's objectives and purposes, the Corporation shall have and may exercise all of the powers conferred by the New York Not-for-Profit Corporation Law in pursuit of the purposes expressed in Paragraph THREE hereof. Without limiting the generality of the foregoing, the Corporation shall have power to sue and be sued, to own, take title to, receive and hold, lease, sell and resell, in fee simple or otherwise, property real, personal or mixed wherever situated and however acquired, without limitation as to amount or value. The Corporation shall have authority to encumber property by deed of trust, pledge or otherwise; to borrow money and secure payment of same by lien or liens of the realty or personal property of the Corporation; to lease, build, erect, remodel, repair, construct and/or reconstruct any and all buildings, houses or other structures necessary, proper or incident to its needs and proposes; and to do

Certificate of Incorporation

any and all things incident to the carrying out of the objectives and purposes as stated and as limited herein. The Corporation shall have full powers or management, investment and reinvestment and the collection of all rents, revenues, issues and profits arising therefrom.

12. The Corporation is to have members.
13. The Corporation is to be divided into such classes of members as the By-Laws provide. The designation of each class of members, the manner of election or appointment, and the qualification and rights of the members of each class (including conferring, limiting, or denying the right to vote) shall be set forth in the By-Laws.
14. The Secretary of State of the State of New York is hereby designated as the agent of the Corporation upon whom process may be served, and the post office address to which the Secretary of State shall mail a copy of any such process served upon him is as follows:
BSC Management, Inc., 11300 W. Olympic Blvd., Suite 600,
Los Angeles, CA 90064.

Constitution

Article I

Section 1. The name of the Corporation shall be The American Head and Neck Society, Inc.

Article II

Section 1. The purpose of this Society is to promote and advance the knowledge of diagnosis, treatment and rehabilitation of patients with neoplasms and other diseases of the head and neck and the prevention of neoplasms and other diseases of the head and neck.

Section 2. It is the objective of this Society to promote and advance research in neoplasms and other diseases of the head and neck.

Section 3. It is the objective of this Society to promote the highest professional and ethical standards.

Article III

Section 1. Members of this Society shall be designated as Fellows, and shall consist of six classes

- (a) Active
- (b) Honorary
- (c) Corresponding
- (d) Senior
- (e) Associate
- (f) Candidate

Section 2. Active Fellows of this Society shall be those who maintain a license to practice medicine and who are actively engaged in diagnosis, treatment and rehabilitation of patients with neoplasms and other diseases of the head and neck and the prevention of neoplasms and other diseases of the head and neck.

Section 3. *Qualifications for Active Fellowship.* An applicant for Active Fellowship shall be a Diplomate of a particular specialty board, or have credentials that are equivalent to those issued by member boards of the American Board of Medical Specialties. Surgeons must be a member

Constitution

of the American College of Surgeons, a Fellow of the Royal College of Surgeons (Canada), or have similar credentials. A significant portion of practice shall be concerned with managing patients with neoplasms and other diseases of the head and neck. Further qualifications and requirements for Active Fellowship are contained in the By-Laws, Article VI, Sections 1 and 2.

Section 4. *Qualifications for Honorary Fellowship.* Honorary Fellowship shall be a distinction bestowed by the Society on an individual who has made outstanding contributions to the field of head and neck oncology.

Section 5. *Qualifications for Corresponding Fellowship.* Corresponding Fellowship shall be granted to those who, in the judgment of the Council, are actively engaged in the prevention, diagnosis, treatment and rehabilitation of patients with neoplasms and other diseases of the head and neck and who reside in a country other than the United States or Canada.

Section 6. *Qualifications for Senior Fellowship.* Any Active Fellow, upon cessation of active practice, may request by writing to the Secretary a change in status to Senior Fellowship.

Section 7. *Qualifications for Associate Fellowship.* A candidate for election to Associate Fellowship shall be a physician, dentist or allied scientist who has demonstrated a special interest in the field of head and neck oncology, but a significant portion of whose practice is concerned with managing patients with non-neoplastic diseases of the head and neck.

Section 8. *Qualifications for Candidate Member.* The trainee currently enrolled in, or a graduate of, an approved residency program in Otolaryngology, Plastic Surgery, or General Surgery or in a Fellowship Program approved by the Joint Training Council may become a Candidate Member. This nonvoting membership is subject to fees established by the Council. The membership shall expire if the candidate member has not made application for Active Fellowship in The American Head and Neck Society, Inc. within five years after the completion of training.

Section 9. *Privileges of Members.* All members shall have the same rights and privileges except that only Active Fellows in good standing shall have the privileges of voting in the conduct of the affairs and business of the Society or of holding office or of chairing Standing Committees.

Article IV

Meetings

Section 1. The annual meeting of this Society shall be held at such time and place as may be fixed by the Council at its annual meeting.

Section 2. The annual meeting shall consist of at least one scientific session and one business session.

Section 3. The scientific session shall be open to all Fellows of the Society and members of the medical profession. Attendance at any business session is limited to Fellows of the Society.

Section 4. Only Active Fellows in good standing shall have the privilege of a vote in conduct of the affairs and business of the Society.

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Article V

Officers

Section 1. The officers of this Society shall be President, President-Elect, Vice-President, Secretary, and Treasurer.

Article VI

Board of Directors

Section 1. The governing body of this Society shall be the Council, consisting of the President, President-Elect, Vice-President, Secretary, Treasurer, and Past Presidents (for a period of three years following the termination of term of office). In addition, there shall be nine Fellows-at-Large, three of whom shall be elected each year to serve terms of three years each. At no time shall the Council exceed eighteen in number. The manner of election of officers and members of the Council is stated in the By-Laws, Article VII, Sections 1 and 2.

Article VII

Amendments to the Constitution or Bylaws

Section 1. A proposed amendment to the Constitution or By-Laws must be communicated to the Secretary in written form not less than two months before a meeting of the Council, and must be signed by at least two Active Fellows. The Secretary shall forward the proposed amendment to the Constitution and Bylaws Committee for review and comment. The Constitution and Bylaws Committee will make a periodic review of the Constitution and Bylaws and recommend modification which may be submitted as amendments. Any proposed amendment must first be acted upon by the council. The Secretary shall submit in written form a copy of any proposed amendment to each Active Fellow not less than one month prior to the annual meeting of the Society. Two-thirds vote of the Active membership present at the meeting shall be required for acceptance.

Bylaws

Article I

Rights and Duties of Members

Section 1. Any Active Fellow shall have all the rights of Fellowship, shall be subject to all the duties, roles and responsibilities incumbent upon the members of any scientific parliamentary body.

Article II

Section 1. *Delinquents.* Unless excused by the Council, a Fellow delinquent in dues for two consecutive years shall be dropped from Fellowship. Delinquency in dues is defined as failure to pay by the end of the calendar year.

Article III

Dues

Section 1. The amount of the Society's dues shall be determined by the Council. The Council shall have the authority to establish an initiation fee or special assessment.

Bylaws

Article IV

Order of Business

Section 1. The regular order of business at annual meetings shall be carried out in a manner prescribed by the Council.

Article V

Special Provisions

Section 1. All conditions, circumstances, emergencies or contingencies not covered by this Constitution and its Bylaws shall be dealt with and administered by the directive of the Society's Council, subject to approval by the membership at the next annual meeting.

Article VI

Qualifications for Fellowship

Section 1. Candidates desiring election to Fellowship in any class other than Associate Fellow must hold a valid, unrestricted license to practice medicine in the state or country in which they reside and shall be proposed by two Active Fellows with at least one from the applicant's local geographical area. A special form will be provided by the Secretary for this purpose. Both of the sponsors must submit letters of recommendation pertaining to the qualifications of the candidate.

Section 2. *Special Qualifications for Active Membership.*

- A. In addition to fulfilling the requirements under the Constitution, Article III, Section 3, surgeon candidates must submit evidence that they have the skill and capacity to diagnose and treat neoplasms and other diseases of the head and neck.
- B. An applicant for Active Fellowship shall provide documentation that he or she has received adequate training in the management of patients with head and neck tumors and that a significant portion of current professional activity is devoted to the care of such patients. Such documentation will include a description of experience during residency and/or fellowship training, a summary of subsequent post training experience, and a listing of at least 35 patients with head and neck tumors managed during preceding year. Additional evidence of academic activity such as one paper published on cancer of the head and neck is required.
- C. Active Fellows must be members of the American College of Surgeons or its equivalent.
- D. Active Fellows are expected to adhere to ethical standards, as detailed in the ethics code of the American Head and Neck Society.

Section 3. *Special Qualifications for Corresponding Fellowship.*

- A. Corresponding Fellows shall be physicians who, by their professional associations and publications, would appear in the judgment of the Council to be qualified to treat neoplasia and diseases of the head and neck. All proposals for candidates for Corresponding Fellowship shall be accompanied by a curriculum vitae of the candidate and a letter of recommendation from at least two Active Fellows.

Section 4. *Election to Fellowship*

- A. All proposals for candidates for any class of Fellowship shall be sent to the Council through the Secretary. Subsequent to approval by the

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Council, nominees' names must be circulated to the membership at least 120 days before the annual meeting. Fellows shall be given an opportunity to make written objections at least 60 days in advance of the annual meeting. Objections will be investigated by the Credentials Committee and presented to the Council for a vote. The Council will use the AMA Code of Ethics as a guide in this matter.

- B. Election to any class of membership shall require three-fourths favorable vote of the Council.
- C. A candidate for Active Fellowship must be present at the annual meeting to be inducted.

ARTICLE VII

Officers of the Society

Section 1. Election of Officers. The officers of the Society shall be a President, President-Elect, Vice-President, Secretary, and Treasurer, who shall be elected at regular annual business meetings of the Society.

Section 2. Accession to Office. The newly elected officers shall assume their duties before the adjournment of the meeting at which they have been elected.

Section 3. Tenure of Office.

- A. The President and President-Elect, and Vice-President shall serve for a term of one year. The vice-president would be expected to advance during the next two years to president-elect and then president, unless the Council specifically directs the Nominating committee differently. The Secretary and the Treasurer shall serve for a term of three years and may be elected to one additional term.
- B. An outgoing President (Past President) automatically becomes a member of the Council to serve for a period of three years. A past-president's membership on the Council which shall be terminated by death or other incapacity to serve shall remain vacant until filled by regular succession.

Section 4. Vacancies in Office. Vacancies in office occurring between elections shall be filled by appointment by the President. These appointments shall be subject to written approval of a majority of the Council. Should the office of the President become vacant between elections, it shall automatically be filled by the President-Elect. Should the offices of both President and President-Elect become vacant, these offices will be served by the Secretary.

Article VIII

Duties of the Officers

Section 1. Duties of the President.

- A. The President shall preside at meetings of the Society and shall have the power to preserve order and to regulate the proceedings according to recognized rules.
- B. The President shall serve as Chairman of the Council.
- C. The President shall appoint standing and special committees, except the Nominating Committee. See Article X, Section 3.
- D. The President shall fill vacancies in offices that occur in the interim between regular meetings subject to approval by a Council majority.
- E. The President shall be an ex-officio member of all standing committees.

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Section 2. *Duties of the Vice President.*

- A. The Vice-President shall serve and assist the President and President-Elect.
- B. The Vice-President shall oversee the work of the committees and shall direct, plan and implement the long range and strategic planning retreat of the Council listed in Article IX section 2E.

Section 3. *Duties of the President-Elect.*

- A. The President-Elect shall perform all duties that may be delegated to him or her by the President.
- B. In the absence of the President, the President-Elect shall perform all duties of the President and shall preside at all meetings.

Section 4. *Duties of the Secretary.*

- A. The Secretary shall keep or cause to be kept in permanent form an accurate record of all transactions of the Society.
- B. The Secretary shall send due notice of all meetings to members; notice of at least 15 days shall be provided prior to Council meetings.
- C. The Secretary shall notify all committee members of their appointments and the duties assigned to them.
- D. The Secretary shall notify all applicants for membership of the action taken by the Society.
- E. The Secretary shall keep a correct alphabetical list of members, together with their current addresses and shall supply application forms to members who apply for same.
- F. The Secretary shall act as custodian of all papers of the Society and its committees.

Section 5. *Duties of the Treasurer.*

- A. The Treasurer shall collect, receive and be accountable for funds accrued by the Society from dues or other sources.
- B. The Treasurer shall deposit all moneys in a special bank account under the official name of the Society, in a city of his choice.
- C. The Treasurer shall disburse from the treasury such funds as may be necessary to meet appropriations and expenses of the Society.
- D. The Treasurer's financial records shall be audited at each regular annual meeting by the Finance committee, who will report at the business session.
- E. The Treasurer shall prepare and submit an annual budget for the following year to the Finance committee for subsequent approval of the Council at the fall meeting.

ARTICLE IX

The Council

Section 1. Composition of the Council. The Council shall consist of the officers, the three immediate Past Presidents, and nine Fellows at Large, three of whom shall be elected annually to serve staggered three-year terms. A Fellow at Large elected to the Council may not succeed himself or herself.

Section 2. *Duties of the Council.*

- A. The Council shall conduct the affairs of the Society during the interim between sessions.

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- B. The Council shall pass on all applicants for Fellowship and present its recommendations to the Society at one of its business sessions so that necessary action may be taken.
- C. The Council shall report to the members at regular business sessions all decisions and recommendations made so as to obtain approval of the whole membership of its actions.
- D. Should the membership disapprove of any action of the Council the questions shall be referred back for further consideration and reported at the next business meeting.
- E. The Council shall have a long range and strategic planning retreat at least every three years.
- F. The Council shall review all Society service contracts with a minimum frequency of five years. This includes, but is not limited to, the official journal of the society and the society management vendor.
- G. The Council shall evaluate requests for endorsement of policies presented by other societies. The President will charge the appropriate committee with reviewing the policy endorsement request and making a recommendation to the Council. The Council will vote on the recommendation and the Secretary will be charged with contacting the requesting society with regard to the outcome of that deliberation. Whenever possible, the President will ask the requesting society to include an active fellow in the initial development of policies which may be related to the AHNS.

Section 3. *Quorum and Manner of Acting.*

- A. A majority of officers and Council members shall constitute a quorum. A majority of the quorum at any meeting of the Council shall constitute action by the Council unless otherwise provided by law or by these By-Laws.
- B. Any action required or permitted to be taken at a meeting of the Council may be taken without a meeting if a consent in writing setting forth the action to be taken shall be signed by all Council members entitled to vote.
- C. Meetings may be conducted by telephone provided that all officers and Council members participating in such a meeting may communicate with each other. A majority of officers and Council members shall constitute a quorum for telephone meetings and the act of a majority of the quorum shall constitute action by the Council.
- D. Officers and Council members shall not receive compensation for their services, but, by action of the Council, expenses may be allowed for attendance at meetings of the Council or for official representation of the Society and the Council may underwrite any activities that it deems essential to the functioning of the Society.

ARTICLE X

Committees and Representatives

Section 1. Other than as specifically stated below, The President shall appoint committee members to serve for three years. Initial appointments shall be staggered such that approximately one-third of committee members shall change each year (other than the Scientific Program Committee and Nominating Committee).

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Section 2. *Scientific Program Committee.* This committee shall be appointed by the President to serve for one year and shall consist of at least three Active Fellows. It shall be the duty of this committee to establish a scientific program at the Annual Meeting.

Section 3. *Nominating Committee.* The Nominating Committee shall consist of the three immediate past presidents and two Active Fellows elected at the business meeting. The Nominating Committee shall be chaired by the immediate past President. This committee shall prepare a slate of officers, three members-at-large of the Council, two Nominating Committee members, one Subspecialty Advisory Council (SSAC) representative of the AAO-HNS (when necessary) and one Finance Committee member for vote at the next annual meeting (See Article VII, section 2).

Section 4. *Credentials Committee.* This committee shall be chaired by the President and shall additionally consist of the two immediate Past Presidents plus two Active Fellows appointed by the President. In addition, the Secretary shall be a member, ex officio. The Credentials Committee shall advise the Council on the credentials of candidates for membership.

Section 5. *Education Committee.* This committee shall consist of at least three Active Fellows. It shall be the duty of this committee to develop appropriate educational activities for the Society.

Section 6. *Research Committee.* This committee shall consist of at least six Active Fellows. It shall be the duty of this committee to: increase the quality and quantity of research conducted in head and neck oncology; encourage the design and implementation of new research protocols; review applications for research funds; and suggest possible new methods of research funding.

Section 7. *Council for Advanced Training in Oncologic Head and Neck Surgery.* This committee shall consist of ten Active Fellows, each to serve a five-year term, with appointments staggered so that two Active Fellows are appointed to membership on this committee each year. The committee shall be chaired by a member chosen from its ranks, by a majority vote, and the chair's term shall be two years with the possibility of a second term. The President's appointments to this committee shall be submitted for approval by the Council. It shall be the duty of this committee to evaluate training programs as to whether they qualify for Phase III training and to make recommendations to this Society concerning what constitutes adequate training in head and neck oncologic surgery.

Section 8. *Constitution and By-Laws Committee.* This committee shall consist of at least five Active Fellows, with the Secretary serving ex-officio. It shall be the duty of this committee to completely evaluate the Constitution and By-Laws a minimum of every three years to maintain their relevance.

Section 9. *Finance Committee.* This committee shall consist of three Active Fellows elected at the business meeting to serve three year terms so that one member is elected each year. The Treasurer shall be an ex officio member. It shall be the duty of this committee to audit the financial records of the Society and review investments and to report at the annual business meeting. This committee shall review the financial reports of the Treasurer prior to the presentation to the Council.

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Section 10. CME Compliance Committee. This committee should consist of at least three Active Fellows. It shall be the duty of this committee to monitor and ensure compliance with the CME requirements of the Accreditation Council for Continuing Medical Education; to review and improve the quality of the educational programs of the Society; and to review annually, prior to the annual meeting, any potential financial conflict of interest of members of the Program Committee, Program Chairs, faculty, and presenters.

Section 11. Quality of Care Committee. This committee should consist of at least three Active Fellows. It shall be the duty of this committee to formulate quality of care standards for patients with head and neck neoplasms; to promote compliance with these standards as a framework for the measurement of quality head and neck care; to disseminate these standards to the membership of the Society; and to provide AHNS representation to the applicable committees of other head and neck medical societies that are charged with the development of specialty specific quality standards upon which pay-for-performance benchmarks may be based.

Section 12. Publications Committee. This committee should consist of at least three Active Fellows appointed by the President. This committee shall be chaired by the Associate Editor for the Head and Neck Section of the Archives of Otolaryngology-Head and Neck Surgery. In addition, the Archives of Otolaryngology-Head and Neck Surgery Editor, if a member of the Society, shall be a member of this committee, ex-officio. The Secretary and President will be members of this committee. It shall be the duty of this committee to assure manuscript submission to the official journal of the Society, the Archives of Otolaryngology-Head and Neck Surgery, prior to presentation at the annual meeting; to assure rapid peer review of submitted manuscripts; and to facilitate the timely publication of the proceedings of the annual meeting in a dedicated issue of the official journal of the Society.

Section 13. Prevention and Early Detection Committee. This committee shall consist of at least six Active Fellows. It shall be the duty of this committee to: develop, facilitate the implementation, and participate in programs directed toward the prevention and early detection of oral and head and neck cancers and to cooperate with national and international organizations in these efforts.

Section 14. Endocrine Surgery Committee. This committee should consist of at least three Active Fellows. It shall be the duty of this committee to increase research and education related to head and neck endocrine disorders, to encourage endocrine-related contributions to the annual meeting, and to foster interaction between the Society and other societies and organizations with interests in endocrine disorders.

Section 15. Website Committee. This committee shall consist of at least three Active Fellows. It shall be the duty of this committee to recommend and implement newer methods to optimize communication or dissemination of information within the organization. The committee shall develop and showcase new and emerging technologies and shall also be responsible for updating and revising the AHNS web site and making sure it is kept with the most current and accurate information.

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Section 16. Awards Committee. This committee shall consist of at least six active fellows, including the Chair. Committee members are appointed by the President. It shall be the duty of this committee to evaluate manuscripts submitted for awards to be given at the annual meeting of the AHNS. An author may submit only one manuscript per award category. Fellows are not eligible for resident awards. Manuscripts will be redacted of all author and institutional identifying information by the chair prior to being sent to committee members for scoring. Manuscripts should be scored by at least five committee members. Manuscripts will not be scored by a committee member if he/she is an author on the paper. The Chair may request a scoring by another qualified AHNS fellow; if not enough committee members are available to score a manuscript. Deadlines for submission of manuscripts will be determined annually and announced during the call for abstracts. Authors of abstracts accepted for oral presentation will be invited to submit a manuscript for an award. The Chair will work with the Program Committee to ensure that award-winning papers are given podium time for oral presentations.

Section 17. History Committee. This committee shall consist of at least three Active Fellows. It shall be the duty of this committee to preserve the history of the society by conducting interviews of past leaders, researching and organizing past records and promoting historical information on the web site and through other mediums.

Section 18. Humanitarian Committee. This committee shall consist of at least three active Fellows. It shall be the duty of this committee to encourage and support volunteer efforts of AHNS members to assist in the care of underserved populations and to develop information, communication, and organizational resources regarding humanitarian outreach activities.

Section 19. Ethics and Professionalism Committee. This committee shall consist of six Active Fellows appointed by the President. Members shall serve for three years. The Committee shall be chaired by one member chosen by the President for a three year term. This committee shall meet on an ad hoc basis at the request of the President to deliberate and offer advice on specific ethical issues that involve the Society or its members. The committee will also maintain and modify as needed, the ethics code of the American Head and Neck Society.

Section 20. Ad hoc Committee(s). As necessary, the President may appoint one or more Ad Hoc committees to serve for one year.

Section 21. Standing Committees. Other standing Committees shall be constituted as described in the Policies and Procedures.

Section 22. Subspecialty Advisory Council (SSAC) Representative. This representative shall be nominated by the Nominating Committee, and elected at regular annual business meetings of the Society. The representative shall have a three year term, with the potential for reappointment for a second term. The person should be someone who has served on Council or the Executive Committee, and is intimately involved with the Society's activities.

Section 23. Head and Neck Reconstruction Committee. This committee should be composed of at least six active fellows. Two members

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are to be appointed annually for a 3 year term by the president of the society. The chairman of the committee will be appointed by the president of the society for a three year term. It shall be the duty of this committee to promote research and education related to head and neck reconstruction, to encourage reconstructive-related contributions to the annual meeting, and to foster interaction between the Society and other societies and organizations with interest in reconstruction or plastic surgery of the head and neck.

ARTICLE XI

Quorum

Section 1. A quorum for any meeting of the Council shall be a majority of those persons then serving as members of the Council.

Section 2. A quorum for the regular business session of the society shall be 18 Active Fellows.

ARTICLE XII

Society Assets

Section 1. The interest in the funds property and other assets of the Society of any member whose membership shall terminate for any reason except the dissolution of the Society shall, ipso facto, immediately cease and such members and the representatives of such member shall have no claim against the Society or against the other members of their representatives or any of them.

Section 2. In the case of dissolution of the Society, the funds, property, and other assets shall be used for the purpose of furthering the expressed purposes for which this Society was formed and no member shall be entitled to receive any of the assets upon liquidation.

Section 3. If the Society's annual receipts exceed the annual expenses in any given year, the Council may, by a majority vote, elect to distribute the surplus for such scientific or educational uses as the Council shall deem to be most consistent with the Society's purposes; or it may, should it reasonably anticipate a need for operating surplus to meet future expenses, accumulate such surplus in an interest bearing account or otherwise.

Section 4. On an annual basis, when the Society accrues money surpassing the agreed upon amount of reserves needed in the accounts (\$200,000 in checking and \$1,000,000 in savings), the Society will transfer x % of the surplus to the corpus of the Foundation. The Council of the Society will determine the percentage of transfer annually by voting at the Council Meeting during the AHNS Annual Meeting.

ARTICLE XIII

Indemnification

Section 1. The Society shall indemnify any and all of the directors or officers former directors or officers, employees, agents, or any person who may have served at its request or by its election as a director or officer of another society or association, or his heirs, executors and administrators, against expenses (including attorney fees, judgments, fines and amounts paid in settlement) actually and necessarily incurred by them in connection with the defense or settlement of any action,

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suit or proceeding in which they, or any of them, are made parties or a party, by reason of being or having been directors or a director, officer, employee or agent of the Society or of such other Society or association, except in relation to matters as to which any such action, suit or proceeding to be liable for willful misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent shall not, of itself, create a presumption that the person is engaged in willful misconduct or in conduct in any way opposed to the best interests of the Society. The provisions of this section are severable, and therefore, if any of its provisions shall contravene or be invalidated under the laws of a particular state, country or jurisdiction, such contravention or invalidity shall not invalidate the entire section, but it shall be construed as if not containing the particular provision or provisions held to be invalid in the particular state, country, or jurisdiction and the remaining provisions shall be construed and enforced accordingly. The foregoing right of indemnification shall be in addition to and not exclusive of other rights to which such director, officer, employee or agent may be entitled.

ARTICLE XIV

Merger Provisions

To facilitate the merger of the Society with The Society of Head and Neck Surgeons, an Illinois nonprofit corporation ("SHNS"), pursuant to an agreement calling for the SHNS to be dissolved and its assets transferred to the Society and the Society recast as The American Head and Neck Society, Inc. ("AHNS") to serve as a successor of both entities, notwithstanding any other provision of the Constitution or these By-Laws to the contrary:

1. The Council shall be expanded as necessary to include the officers and directors of the SHNS, who shall serve on the Council with their voting status as provided by the SHNS bylaws until their term of office within the SHNS shall expire. The Council shall return to its size and with its composition provided in Article IX hereof through the passage of time.
2. The President-Elect of the SHNS shall become as President-Elect of the AHNS following the completion of his term as President-Elect of the SHNS. The President-Elect of the Society shall become President of the AHNS to serve a term of six months (i.e., from May 15, 1998 through November 14, 1998), whereupon the said President-Elect of the SHNS shall serve as President of the AHNS to serve a term of six months (i.e., from November 15, 1998 through the membership meeting in May of 1999 or until his successor shall assume office). During the combined one-year term of office, the two said individuals shall regularly consult and cooperate with each other on all meaningful and significant decisions to be made during the year so that it may appear that they are serving as co-presidents for the full year, provided, however, that the AHNS shall have only one President in office at one time. At the conclusion of this one-year term, the President-Elect next in line shall succeed to the Presidency.

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3. The members of the SHNS shall be admitted to the Society recast as the AHNS in the membership category that correspond to that which they hold in the SHNS. More specifically, Active Members of the SHNS shall become Active Fellows of the AHNS; Senior Member of the SHNS shall become Senior Fellows of the AHNS. Consulting Members of the SHNS shall become Associate Fellows of the AHNS. International Corresponding Members of the SHNS shall become Corresponding Members of the AHNS. Honorary Members of the SHNS shall become Honorary Fellows of the AHNS. Candidate Members of the SHNS shall become Candidate Members of the AHNS.
4. The Council shall act to preserve the unique heritage and history of the SHNS and the ASHNS.

AHNS 2013 ANNUAL MEETING

During the Combined Otolaryngology Spring Meetings

Thank You to Our Corporate Supporters!

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