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*This Issue of the AHNS Journal Club has been compiled and reviewed by members of the **AHNS Global Outreach Committee:***

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Educational workshops with graduates of the University of Cape Town Karl Storz Head and Neck Surgery Fellowship Program: a model for collaboration in outreach to developing countries.

J. J. Fagan, J. Aswani, J. Otiti, V. Mushamba, E. Liyombo, G. Woodson, D. Weed, C. Zender, K. Mannion, J. L. Netterville, R. Wagner and Mark Zafereo

From **SpingerPlus**, September, 2016

The University of Cape Town Karl Storz Head and Neck Surgery Fellowship is the only head and neck surgery fellowship in Sub-Saharan Africa. This article briefly describes this fellowship and outlines the experience and ongoing collaborative efforts of members of the American Academy of otolaryngology-head and neck surgery with graduates of this program who are now building head and neck surgery programs in East Africa. This educational collaboration avoids many common pitfalls associated with short-term humanitarian outreach and represents a successful model for international collaborative educational efforts with head and neck surgeons in developing countries in Africa.

Summary statements

- The article provides background of the Karl Storz head and neck surgery fellowship which has trained 10 sub-saharan African otolaryngologists/general surgeons in procedures such as

parotidectomy, neck dissection and laryngectomy. These fellows then uniformly return to their home country to provide higher-level patient care and to establish regional head and neck programs.

- The article explains how the inability of the fellowship program to provide meaningful ongoing educational support has given the AAO/HNS an opportunity to work with the fellows to grow and establish their own head and neck programs.
- The authors explain how, with the individual fellow, they organized one to two week workshops/surgery camps in major academic centers that typically consist of 1-2 days of didactic lecture, 1-2 days of cadaver lab followed by 2-3 days of hands-on surgery for previously selected patients.

Strengths

- The obvious pitfalls of short humanitarian medical trips were objective and well-explained, and include: uncertainty of patient selection and follow up, potential interruption of the local medical communities efforts, language/cultural gap‘s and potential for a well-meaning visiting doctors to undermine the authority of local medical colleagues.
- The ultimate results of these workshops/surgery camps were also well described, and include: provision of continuity of care for patients, creation of enthusiasm for this level of care, building of international relationships, increased participation of the local medical community, and bridging of cultural and language barriers between visiting surgeons and African patients.
- Importantly, the authors recognized that the fellows were central to the success of each workshop/surgery camp in terms of organization and optimizing participation, and gave specific examples of several fellows who went on to build head and neck programs in their own countries and who have used these relationships to create further opportunities for international collaboration.

Weaknesses

- It was unclear who or what organization funded each workshop/surgery camp.
- It is somewhat ambiguous how other academic institutions or committed individuals can become involved in these efforts other than being members of AAO.HNS or AHNS.
- A minor point, but the difference (if any) between a surgery camp and a head and neck workshop was not explained.

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Head and neck surgical subspecialty training in Africa: Sustainable models to improve cancer care in developing countries.

Fagan JJ, Zafereo M, Aswani J, Netterville JL, Koch W.

*From **Head & Neck**, March 2017*

Background: Cancer poses a health crisis in the developing world where surgery is the mainstay of treatment for head and neck cancers. However, a shortage of surgeons with appropriate skills exists. How do we train head and neck surgeons in developing countries and avoid a brain drain? The ideal model provides appropriate affordable training leading to establishment of head and neck cancer centers that teach and train others.

Methods. Different head and neck surgery training models are presented based on the personal experiences of the authors. Surgical exposure of head and neck fellows in Cape Town and (potentially) in Nairobi is benchmarked against programs in the United States.

Results. Surgical exposure in Cape Town is equivalent to that in the United States, but more appropriate to a developing world setting.

Conclusion. Training can be achieved in a number of ways, which may be complimentary. Fellowship training is possible in developing countries.

Summary: Disparities are well known between care delivered in low verse high resource settings. Considering the huge resource burden associated with radiation and chemotherapy is prohibited for much of Africa, the treatment of head and neck cancer with a heavy emphasis on surgical management is an evolving paradigm.

- Points to the success of 'centers of excellence' within the low resource setting, incorporated with pulsed ‘surgical camps’ from the developed world results in improved delivery of head and neck cancer care in developing countries.
- Highlights surgical exposure in these African 'centers of excellence’ is equivalent to programs in the United States but focuses on training in the environment that has limited resources and limits the major concern for ‘brain drain’ after training is complete.
- Elaborates on the decision-tree differences in surgical approaches to cancer, specifically that of the larynx.

Strengths

- Brings to light the controversies of advanced training for surgeons in resource-depleted environments.
- Highlights solutions to providing cancer care where chemo and radiation are not a reliable or available resource.
- Carefully considers the pitfalls associated with translating US training experiences to the developing world.

Weaknesses

- Expert opinion paper

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Formation of an international intergroup to coordinate clinical trials in head and neck cancers: HNCIG

Le QT, Welch JJ, Vermorken JB, Rischin D, Mehanna H; all HNCIG investigators.

*From **Oral Oncology**, August 2017*

Clinical trials in head and neck cancer (HNC) face multiple challenges including low global incidence, excessive patient comorbidity rate, high treatment-related toxicity and more recently a changing tumor biology landscape. As clinical trials evolve to address new knowledge about HNC biology, the overall pool of eligible patients for each trial becomes smaller, leading to more accrual challenges. These challenges have led to the formation of the Head and Neck Cancer Intergroup (HNCIG) comprised of large HNC international and national cooperative groups and sites with the goal of facilitating the conduct of high quality clinical trials in a timely manner to improve outcomes in HNC. This article describes the objectives, structure, and activities of the HNCIG

Summary: Commentary describes a newly formed Head and Neck Cancer Intergroup (HNCIG) to administer international clinical trials.

- The mission of the HNCIG is to create a harmonized platform to conduct trials together in subgroups and to maximize patient accrual.
- The HNCIG is comprised of any clinical research network or high-accruing single institution.

Strengths :
It has been reported that 13% of all head and neck cancer clinical trials are ended due to inadequate patient accrual. Furthermore, trials results often take a long period of time to mature due to slow accrual. The newly formed HNCIG seeks to address both of these issues by coordinating international trials and recruitment. This will enable the trials to meet target enrollment sooner than if these were done in a single clinical research network. HNCIG will also promote international collaboration and studies of rate tumors.

Weaknesses
It will be a challenge for the HNCIG to overcome the regulatory and legal hurdles in performing international research. Furthermore, there will need to be standardization of treatment modalities, feasible trial endpoints, and ability to analyze data across different health practices and systems. Fortunately, the HNCIG have a model to follow in the Gynecological Cancer Intergroup that have an established platform for international trials in GYN malignancies.

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Surgery and Global Health: A View from Beyond the OR

Paul E. Farmer & Jim Y. Kim

*from **The World Journal of Surgery**, April 2008*

In Africa, surgery may be thought of as the neglected stepchild of global public health. There are fewer physicians per population on this continent than on any other; surgeons are rarer still, and almost all of them work in the urban enclaves of what remains a rural region. The story is the same in the poorer parts of Asia and Latin America (with a few exceptions, such as Cuba). Although disease treatable by surgery remains a ranking killer of the world's poor, major financers of public health have shown that they do not regard surgical disease as a priority even though, for example, more than 500,000 women die each year in childbirth; these deaths are largely attributable to an absence of surgical services and other means of stopping post-partum hemorrhage. Global health currently attracts unprecedented interest among surgeons, especially those in training, for whom residency programs and fellowships should be further developed, as is now occurring in medicine. Field experience remains an important teacher. Providing even the most basic surgical services to those previously unserved requires infrastructure, training, supplies, and experienced personnel. The one thing not required is surgical disease, which exists abundantly among the world's poorest. To bring a greater number of surgeons into the campaign for public health unrestricted by ability to pay will involve enlarging the horizons of both the surgical and public-health professions.

Summary:

- Historically, surgical services have not been a focus of global health initiatives.
- The surgical burden of disease globally in LMIC is tremendous and offers an opportunity for surgeons to have a significant impact in global health.

- The need to improve access and availability of surgical programs in LMIC is at a critical level. Creating surgical services is more complex than programs built around communicable diseases and will require partnerships with local hospitals and health personnel that enhance all aspects of surgical care.

Strengths:

- A well written review article by experts in the field (Dr. Paul Farmer) discussing the challenging topic of surgery and global health.
- The reasoning regarding the need to invest in surgical outreach programs is data driven and well stated.
- Discussed many of the challenges seen when trying to create a surgical outreach program and important considerations when doing so.

Weaknesses:

- The role surgery can and needs to play in global health is an important topic and this article could have been more comprehensive and specific.
- More concrete or specific recommendations along with several in depth analysis of successful outreach programs in various specialties would have been valuable.

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