Otolaryngology – Head and Neck Surgery at Weill Cornell Medical College

Otology and Neurotology
Rhinology and Sinus Disorders
Laryngology, Voice, and Dysphagia
Head and Neck Surgery
Pediatric Otolaryngology
Plastic and Reconstructive Surgery
General Otolaryngology

FIFTH EDITION

BREAKING THE SOUND BARRIER
How We Are Advancing Treatment for Hearing Loss

NewYork-Presbyterian
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7th Annual Symposium

OTOLARYNGOLOGY UPDATE IN NYC

Featuring Distinguished Local and National Faculty

October 24 - 25, 2013

Course Description
This 2-day course will provide the practicing Otolaryngologist-Head and Neck Surgeon with an update on the latest diagnostic and therapeutic techniques, including surgical management for the following subspecialties:

• Otology and Neurotology
• Rhinology and Sinus Disorders
• Laryngology, Voice, and Dysphagia

Course Co-Directors
Michael G. Stewart, MD, MPH
Professor and Chairman
Department of Otolaryngology – Head and Neck Surgery
Weill Cornell Medical College
Vice Dean
Weill Cornell Medical College

Samuel H. Selesnick, MD
Professor and Vice Chairman
Department of Otolaryngology – Head and Neck Surgery
Weill Cornell Medical College

Special Guest Faculty
Robert C. Kern, MD
Chairman
Department of Otolaryngology – Head and Neck Surgery
Northwestern University
Feinberg School of Medicine

Gregory N. Postma, MD
Director
Center for Voice and Swallowing Disorders
Medical College of Georgia

Ashok R. Shaha, MD
Chairman, Head and Neck Surgery and Oncology
Memorial Sloan-Kettering Cancer Center

Steven A. Telian, MD
Professor, Otolaryngology
University of Michigan
Health System

Tom D. Wang, MD
President
American Academy of Facial Plastic and Reconstructive Surgery
Oregon Health and Science University

Regional Guest Faculty
Dean C. Mitchell, MD
Clinical Assistant Professor
Touro College of Osteopathic Medicine

Weill Cornell Medical College
Department of Otolaryngology – Head and Neck Surgery Faculty

Kevin D. Brown, MD, PhD
Marc A. Cohen, MD
Ashutosh Kacker, MBBS
Michelle L. Kraskin, AuD
William I. Kuhel, MD
David I. Kutler, MD
Joshua I. Levinger, MD
Kate E. McCarn, MD
Vikash K. Modi, MD
Joseph J. Montano, EdD
Aaron N. Pearlman, MD
Mukesh Prasad, MD
William R. Reisacher, MD
Rita M. Roure, MD
Lucian Sulica, MD
Maria V. Suurna, MD
Andrea Wang, MD

Weill Cornell Medical College
Guest Faculty

Vijay K. Anand, MD
Gina Czark
Hillary D. Johnson, MD, PhD
Gary J. Lelli, Jr., MD
C. Douglas Phillips, MD
Haviva Veler, MD

Columbia University College of Physicians and Surgeons
Otolaryngology Residency Guest Faculty

Lanny Garth Close, MD
Chairman, Department of Otolaryngology – Head and Neck Surgery
Chandra M. Ivey, MD
Anil K. Lalwani, MD
Jaclyn B. Spitzer, PhD
Monica Tadros, MD

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We are pleased to bring you the latest brochure from our Department. Since our last report, we have celebrated many notable events. At the Medical College, we are concluding a $1.3 billion fundraising campaign – the largest ever by a medical college – capped off by the construction of the new Belfer Research Building on our Upper East Side Manhattan campus. Weill Cornell has welcomed a new Dean, Dr. Laurie Glimcher, who is already making a significant positive impact on the College, including the recruitment of a Director for our new Cancer Center. We have also opened a beautiful new outpatient practice facility on the Upper West Side, and the Department of Otolaryngology – Head and Neck Surgery will play a major role at that location. Our partner hospital, NewYork-Presbyterian Hospital, is completing a merger with New York Downtown Hospital in lower Manhattan, which will be another campus for the Weill Cornell faculty practice expansion and our Department will have two faculty based there this year. I was also honored to be appointed by Dean Glimcher as the Vice Dean of the Medical College in 2012.

In the Department, Dr. Sam Selesnick has completed his term as President of the American Neurotology Society, and I completed my term as President of the Association of Academic Departments of Otolaryngology-HNS. Several of our faculty hold leadership positions in regional and national societies, including Dr. William Reisacher, who was elected to the Board of the American Academy of Otolaryngic Allergy, and Dr. David Kutler, who serves as President of the New York Head and Neck Society. The Weill Cornell/NewYork-Presbyterian Center for the Performing Artist – which is based in our Department – continues to grow, and is now an official health care provider for the Metropolitan Opera and the Juilliard School, as well as providing care for many others in the large performing artist community in New York City. Our clinical programs all continue to grow and prosper, and we sponsor several highly rated and well-attended CME and CEU programs every year.

Thanks again for your interest in our Department, and we hope you enjoy the brochure.

Sincerely,

Michael G. Stewart, MD, MPH
Professor and Chairman
Department of Otolaryngology – Head and Neck Surgery
Vice Dean
Weill Cornell Medical College
The Department of Otolaryngology – Head and Neck Surgery recently celebrated the opening of its West Side Practice offices, located within the new Weill Cornell Physician Organization's multíspecialty practice located at 84th Street and Broadway. The Department’s West Side Practice provides the same comprehensive care available through its primary practice site in the Weill Greenberg Center at 1305 York Avenue.

A brightly lit and spacious waiting room provides a warm welcome to patients, while large and modern exam rooms enhance the patient care experience. Hearing testing and hearing aid services are also available in the new facilities.

Members of the Department of Otolaryngology – Head and Neck Surgery join in the opening of the new Weill Cornell West Side Practice facility. They are (from left) Marc A. Cohen, MD; Samuel H. Selesnick, MD, Vice Chairman; Kate E. McCarn, MD; Vikash K. Modi, MD; Joseph J. Montano, EdD; Maria V. Suurna, MD; and David I. Kutler, MD.
In the Department of Otolaryngology – Head and Neck Surgery of Weill Cornell Medical College, an interdisciplinary team of surgeons, audiologists, and clinician-scientists are pooling their respective expertise and resources to advance treatment for individuals with severe to profound sensorineural hearing loss.

“Refining criteria for cochlear implant candidates, pursuing progress in cochlear implant surgical techniques, and researching hearing loss at its most basic level are the key components of the Department’s efforts to improve the outcomes for those who are hearing impaired,” says Samuel H. Selesnick, MD, Vice Chairman for the Department and a specialist in otology and neurotology. “The collaboration among our cochlear implant team members allows for optimal selection of patients and the seamless exchange of relevant information. It is particularly important in the management of expectations on the part of the patient and the patient’s family.”

ATTACKING HEARING LOSS IN THE LABORATORY

Accumulation of free radicals, which can be caused by environmental stress from intense noise, aging, and trauma, plays a key role in hearing loss and cell death in the inner ear. Kevin D. Brown, MD, PhD, is trying to alter these outcomes through research he is pursuing in the laboratory on a class of molecules called sirtuins.

“Sirtuins have been found to extend life in some cell types and simple organisms,” explains Dr. Brown. “As research has begun to unravel the mechanisms of how sirtuins exert this effect, attention has focused on cell types that are acutely sensitive to the effects of aging. One such cell type is the hair cells and neurons of the inner ear, which can degenerate leading to hearing loss associated with aging. If you can increase the activity of sirtuins, you can increase longevity of these organ systems. There have been some reports that suggest that if an animal is calorie restricted, which activates this particular class of enzymes – particularly sirtuin-3 – they could actually prevent age-associated hearing loss.”

From that initial research, Dr. Brown began to look at ways to activate these sirtuins independent of calorie restriction. “One of the ways to sirtuin activity is to increase a particular energetic coenzyme called NAD found in all living cells,” says Dr. Brown. “By increasing levels of this particular component you can actually activate these enzymes. I wanted to identify whether these compounds could prevent hearing loss.”

Looking at noise-induced hearing loss, Dr. Brown and his colleagues used genetically modified mouse models to both...
naturally produce more NAD or to have more of sirtuin-3. They evaluated whether these animals were less likely to have hearing loss from a free radical injury, specifically noise exposure. They found that this was, in fact, the case. Animals that either had an increased capacity for producing NAD or an increased level of sirtuin-3 were found to be protected against noise-induced hearing loss. Dr. Brown, in collaboration with Weill Cornell colleagues Samie R. Jaffrey, MD, PhD, Professor of Pharmacology, and Anthony A. Sauve, PhD, Associate Professor of Pharmacology, then utilized a compound synthesized by Dr. Sauve that could increase NAD and administered it to the animals before they were subjected to noise exposure that would typically cause injury to the cochlea. “We found that this drug effectively prevented them from having both the short-term transient loss as well as the long-term loss of hearing that occurs with noise exposure,” says Dr. Brown. “We were able to demonstrate that the compound, nicotinamide riboside, activates sirtuin-3 and prevents these animals from developing the typical type of hearing loss that occurs with noise exposure. This was really quite incredible.” Dr. Brown is now evaluating which structures within the cochlea are protected against noise-induced injury with this compound. The goal of this research is to provide an alternative pharmacologic approach to damage associated with acute inner ear injury, whatever the cause. “What is particularly interesting,” says Dr. Brown, “many, if not all, of the conditions that lead to hearing loss utilize a common pathway where there is free radical injury. We may be able to prevent in a very logical fashion those types of injuries – whether from Meniere’s disease, noise exposure, aging, or other types of injury – from leading to permanent hearing loss.”

**ADVANCING COCHLEAR IMPLANT TECHNIQUE AND TECHNOLOGY**

In the Department’s Hearing and Speech Center under the direction of Joseph J. Montano, EdD, 17 certified audiologists and speech language pathologists provide state-of-the-art diagnostic and rehabilitative services for disorders of hearing, speech, language, voice, and swallowing for children and adults. As Hannah E. Shonfield, AuD, Supervisor, Audiology, explains, “Many patients – especially those who are dissatisfied with their current hearing aid – come in seeking information about cochlear implants in the hope that they are a candidate for this device. But if they are not, we examine what we can do to rehabilitate their hearing loss through other avenues.”

Michelle Kraskin, AuD, Supervisor, Audiology, specializes in pediatric patients needing cochlear implants, with their youngest patient implanted at nine months. “Children who have bilateral profound sensorineural hearing loss are implant candidates as long as the cochlear nerve is present,” says Dr. Kraskin. Drs. Shonfield and Kraskin collaborate with Dr. Selesnick and Kevin D. Brown, MD, PhD, not only on clinical care for adults and children who are cochlear implant...
candidates, but also on research to further advance this technology. When Dr. Brown joined Weill Cornell, he brought with him advanced training in minimally invasive cochlear implant surgery having trained as a fellow at the University of Miami, which pioneered the procedure. “The faculty there determined that you could successfully implant the cochlear device with a much smaller incision – 4.5 cm behind the ear – and less invasive approaches than had been typically performed,” says Dr. Brown. Currently, instead of performing a specific bony fixation of the device, Dr. Brown and his colleagues have been using a soft-tissue subperiosteal pocket to accommodate the implant. “The technique works extremely well,” says Dr. Brown. “The cochlear implant sits in a very tight pocket between the bone and the pericranium, which is the layer of connective tissue over the skull, and holds the device in place. We then suture the bottom of the pocket to tighten it further so that the pocket is the exact size of the implant. Because the technique eliminates the necessity of drilling into the skull, it is particularly advantageous in children as their skulls are very thin.”

Weill Cornell faculty recently completed a study to evaluate the placement of the receiver-stimulator in the subperiosteal pocket in the standard implant position in light of concerns regarding migration of the receiver-stimulator and damage to a non-recessed electrode lead. “We wanted to determine the incidence of these potential complications by prospectively evaluating a cohort of patients receiving cochlear implants at Weill Cornell using the subperiosteal pocket technique, which does not require bony drilling of the calvarium or exposure of the dura,” says Dr. Selesnick.

In traditional procedures, the receiver-stimulator component is seated in its place by drilling a well into the calvarium that houses the receiver-stimulator unit, which is then secured using fixation via bony tie-down sutures. This technique carries with it a small but veritable risk of intracranial complications, such as a cerebrospinal fluid leak, subdural hematoma, and epidural hematoma, and has also been associated with instances of receiver-stimulator migration. “Migration can lead to uncomfortable or dysfunctional interaction with the external speech processor and requires revision surgery,” says Dr. Brown, who specializes in the surgical rehabilitation of hearing loss by cochlear implantation.

Their study looked at 31 ears (18 adults, 13 children) implanted utilizing the subperiosteal pocket in the standard implant position.
technique, with an average patient age of 22 months for children and 58 years for adults. “Our findings support the safety and efficacy of the subperiosteal technique,” notes Dr. Selesnick. “There were no cases of receiver-stimulator migration or intracranial complications.”

The surgeons also found the technique amenable to varied positioning of the receiver-stimulator to accommodate anatomical factors and the age of the patient. Importantly, if any difficulty in fitting the receiver-stimulator using the subperiosteal pocket is encountered during surgery, the approach may be converted to the standard technique during device implantation. However, the team has to date not needed to convert any cases to the traditional approach. The study is ongoing and the team will continue to follow implanted patients, as well as enroll new patients.

“Our findings support the safety and efficacy of the subperiosteal technique. There were no cases of receiver-stimulator migration or intracranial complications.”

— Samuel H. Selesnick, MD

According to Dr. Brown, another important consideration during cochlear implantation is preventing injury to the cochlea during the procedure. “When you put a cochlear implant in the cochlea, the hair cells that are responsible for picking up the vibration of sound and converting it to an electrical signal that goes to the brain stem can become injured or lost either immediately or over time after the implant is placed,” says Dr. Brown. “This is of particular concern in patients who still have some residual hearing – particularly in the lower frequencies. So we are looking at interventions that help to preserve the natural structure of the cochlea and prevent its degeneration. There has been some success with the use of steroids, but newer compounds that can help prevent degeneration will be extremely helpful.

“We are very excited about some of the newer applications of cochlear implants,” notes Dr. Brown. “One of the major applications that I believe is going to become an important treatment modality is for patients who have lost hearing on one side – particularly for those who have lost it recently – and have normal hearing in the other ear. Although this may seem logical to people outside the field, to people inside the field it’s revolutionary because we have always thought that a patient would not be able to process both the electrical information provided by an implant and the acoustic information provided by normal hearing. It would be like someone speaking in Japanese in one ear and German in the other.”

Notes Dr. Brown, important work in this area is increasingly demonstrating that patients who completely lose hearing in one ear but have normal hearing in the other do much better with a cochlear implant than they do with basically any other treatment modality currently available. As the brain adapts, they are able to incorporate both acoustical and electrical information and use it in a way that improves speech understanding, sound localization, and quality of life.

Dr. Brown and colleagues are currently embarking on an extensive prospective study evaluating changes in quality of life, perceived hearing handicap, and tinnitus handicap in patients that have lost hearing on one side and receive a cochlear implant.
The group had its origins when Drs. McCarn, Cohen, Johnson, Desman, and others got together to talk about a specific case. "We thought it would be a good idea if we held regular discussions to review difficult cases," recalls Dr. Cohen. "That way everyone could be on board with all of the issues that arise with patients who need care from multiple experts." The group now gathers monthly to review and develop treatment plans for challenging cases. It also serves as a forum for discussing new research and topics of common interest and provides an educational opportunity for residents as well.

"When people have cancer, it really requires input and intervention by multiple practitioners," says Dr. Cohen. "The best thing for the patient is a group of people with different areas of expertise who together develop a treatment plan. The Cutaneous Oncology Group was formed to enable all of us to provide that kind of collaborative and comprehensive care for our patients."

Dr. Kutler agrees. "It used to be, at least for skin cancer, that we would work independently. Some of these skin cancers, especially complicated tumors with aggressive behaviors that cross multiple boundaries, need a multidisciplinary approach," says Dr. Kutler. "The group allows us to provide better care for these more complicated cutaneous malignancies."

According to Dr. Kutler, head and neck surgeons become involved in planning and treatment when the cancer is more invasive, reaching into deeper structures where the eye, nose, or skull base is involved, or if the cancer metastasizes to the neck. "With deeper melanomas, we will also be called in to do sentinel node biopsies to determine the extent of the cancer," says Dr. Kutler. "You really need a team to care for patients with invasive skin cancers."

Through the Cutaneous Oncology Group, patients receive seamless care within the same facility on the same day. For example, Dr. Johnson will perform Mohs surgery to remove a cancerous growth and, depending on the extent of tissue removed, she will refer the patient to Dr. McCarn, whose office is only four floors below. Dr. McCarn will then address any facial restoration or reconstruction that is needed that same day. Appointments with a head and neck surgeon will also take place, if necessary.

"It really is a collaborative effort," says Dr. McCarn. "For patients who have very big cancers or complex defects, we are able to coordinate their visits with each of the appropriate medical or surgical specialists, most of whom are located in the same..."
building. This not only optimizes the success of treatment, including functional and aesthetic outcomes, it also makes the overall experience for the patient much less stressful.”

“It’s great for the patient when the doctor can come back and say, ‘Listen, I talked to seven other people about you, and we all agree that this is the right thing to do,’” says Dr. Cohen. “The more experience that you have with an issue, the more informed your decisions will be. So if you have multiple people with years of experience getting together, the decisions about how to treat the patient will be that much better.”

Spearheaded by Weill Cornell dermatopathologist Dr. Garrett Desman, whose research interests are focused on adnexal neoplasia and malignant melanoma, the team has begun investigating melanocytic tumors of uncertain malignant potential – a subset of rare skin cancers that are more aggressive than the typical skin cancer – to identify what makes these tumors different. According to research reported in 2005 in *The New England Journal of Medicine*, melanoma should not be classified as one disease since it appears to have distinct developmental pathways related to anatomic site, degree of sun exposure, genetics, and possibly other factors. With the rate of cutaneous melanoma continuing to rise and the fact that currently no effective treatments are available for advanced melanoma, defining differences among the different types is of paramount importance.

“We are compiling tissue samples and data on patients with these interesting tumors to one day allow us to identify the more aggressive tumors,” says Dr. McCarn. “This will enable us to predict which patients may need treatment earlier and which interventions will lead to the best outcomes.”

To investigate the usefulness of a novel marker for melanocytic proliferations, Dr. Garrett Desman and his colleagues used a novel monoclonal antibody against soluble adenylyl cyclase, immunostaining various benign and malignant melanocytic proliferations.
When Thomas Murry, PhD, speaks, people listen. An internationally recognized voice scientist and speech-language pathologist with more than 40 years of clinical and research expertise in voice disorders, Dr. Murry has authored or coauthored 12 books for speech pathologists and otolaryngologists.

For more than a decade, Dr. Murry has had a particular interest in paradoxical vocal fold motion (PVFM) — a laryngeal disorder that disrupts breathing even though the lungs may be normal. "Paradoxical vocal fold motion disorder is an abnormal closing of the airway with the vocal folds when somebody inhales," explains Dr. Murry. "When we take a breath in, our vocal folds are supposed to be wide open. But when patients who have PVFM take a breath in, their vocal folds start to close. The paradox is that the vocal folds are closing when they should stay open."

Dr. Murry, who sees about 50 people a year, primary ages 12 to 25, with this unusual condition, notes that it often begins after an upper respiratory infection and can develop into a significant quality of life issue, causing shortness of breath and difficulty breathing upon exertion, including during speaking. Some patients are hypersensitive to certain odors. The smell of diesel or certain foods may be a trigger, profoundly affecting the ability of patients to maintain an open airway.

In young people with this disorder, the most common misdiagnosis is exercise-induced asthma, but on pulmonary examination their lungs are normal. “These kids rarely have asthma or other pulmonary diseases. They have an airway issue at the level of the vocal folds,” says Dr. Murry. “In the early ’70s the National Jewish Hospital in Denver published a paper that reported on patients who were refractory to asthma treatment and instead had a voice disorder. Pulmonologists referred to it as vocal cord dysfunction; ENT specialists gave it the name paradoxical vocal fold motion disorder.”

PVFM is diagnosed with laryngeal endoscopy. “We look at the vocal folds with a flexible endoscope, which allows us to actually see this closing motion,” says Dr. Murry. In an article published in the December 2011 issue of Respiratory Medicine, Dr. Murry and his colleagues report on a study they undertook using both endoscopy and spirometry during periods of no exercise to determine the differences between patients with PVFM compared to a group of normal subjects — one of the first studies of its kind. The data confirmed that in patients with PVFM, inspiratory spirometric values play a role in diagnosis. Additionally, the majority of the PVFM subjects showed vocal fold closure following a speech utterance while the control group did not — a finding that warrants further investigation.

Treatment involves respiratory retraining — a series of increased resistance breathing exercises based on the rhythm of breathing and the manner of breathing — and outcomes reviewed on a case-by-case basis are showing success. “Once patients can maintain that rhythm of breathing by not holding their breath and by not taking big breaths, we start to increase the resistance — first by putting them on a bicycle, then by having them climb steps and, eventually, we have them run. Through this combination of behavior modification and physical training, breathing starts to improve within four to eight visits.”

Dr. Murry and his colleagues continue to raise questions worthy of research, including determining how often the condition occurs and whether cases can resolve without treatment.
Clinical Innovation: A New Tool to Test for Allergies

The work of William R. Reisacher, MD, is “nothing to sneeze at.” Dr. Reisacher is developing a diagnostic strategy for non-allergic rhinitis in which individuals appear to have classic allergic symptoms but whose skin and blood tests are negative. “The cause of the symptoms remains unclear,” says Dr. Reisacher. “What’s been known for many years is that the lining of the nose, and some of the other tissues inside the mouth and the throat, are able to produce all of the allergy antibodies that they need right in that area. Many people will have those antibodies in a local environment, such as in the nasal cavity, but they’re not going to have any evidence for it in the blood or in the skin.”

Local antibodies have been found to play a role not only in non-allergic rhinitis, but in many other conditions, such as nasal polyps, allergic fungal sinusitis, and chronic rhinosinusitis. “These patients look like they have allergies, but some estimates suggest that 45 to 50 percent of those patients who test negative will have allergy antibodies in their nose,” notes Dr. Reisacher. “So the ability to test for these antigen-specific antibodies is of primary importance not only for establishing the correct diagnosis, but also to open up other avenues of treatment.”

To date, testing for local antibodies has involved invasive and difficult procedures. The thrust of Dr. Reisacher’s research was to find a less invasive way of testing for local antibodies. “I used what I call a mucosal brush biopsy,” explains Dr. Reisacher. Using a cytology brush to collect both mucus and surface epithelial cells of the nasal lining, he then processed those cells in a salt water solution, testing them for antibodies using blood serum testing equipment recalibrated for saline. That first study was a landmark proof of concept that antigen-specific antibodies inside the nose could be measured using the brush biopsy.

Dr. Reisacher then embarked on additional studies using the mucosal brush biopsy on oral cavity mucosa to see if it might represent a novel, non-invasive testing method for people with food allergies, demonstrating that the brush biopsy – especially when taken from the vestibule – correlated much better with clinical symptoms than blood testing.

“I would say that almost everybody who has allergies has antibodies in the local area,” says Dr. Reisacher. “What’s interesting is that the patients who don’t have antibodies elsewhere, and only have antibodies in the local area, those people tend to be missed. So it’s important to not only do systemic testing, but local testing as well.”

Dr. Reisacher’s invention of the mucosal brush biopsy represents a less invasive form of testing that may appeal to more people who are concerned about allergies, but it also has implications in sinonasal research and any research where patients are categorized based on their allergic status.
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By Invitation Only

Faculty of the Department of Otolaryngology – Head and Neck Surgery are frequently invited around the world to serve as visiting professors or share their expertise at meetings held by professional societies and organizations. Following are a selection of some recent speaking engagements – here and abroad.

Ashutosh Kacker, MBBS, was invited to participate in panel discussions on sleep apnea at The Triological Society Annual Meeting in San Diego, and skull base surgery at the Summer Sinus Course of the American Rhinologic Society in Chicago; the 2012 American Austrian Foundation Otolaryngology Update in Salzburg, Austria; and the 10th International Congress of Otorhinolaryngology Head & Neck Surgery in Ankara, Turkey.

David I. Kutler, MD, served as a member of the faculty of the 2011 American Austrian Foundation Otolaryngology Update in Salzburg, Austria, and the 2011 Otolaryngology Satellite Course in St. Petersburg, Russia.

Joseph J. Montano, EdD, spoke on Patient-Centered Care: Fact, Fiction or Fluff at the Ida Institute Seminar 6A, in Skodsborg, Denmark.

Thomas Murry, PhD, served as a visiting professor at the University of South Florida, Department of Speech Pathology and Audiology, Orlando; the Santa Clara University, Department of Bioengineering, Santa Clara, California; and the University of Hong Kong, Department of Speech and Hearing Sciences.

Vikash K. Modi, MD, was an invited participant at the European Society of Pediatric Otorhinolaryngology meeting in Amsterdam.

Samuel H. Selesnick, MD, was an invited speaker at the Politzer Society of Otology and Neurotology in Athens, Greece, at both the University of Colorado and Vanderbilt University meetings in Vail, and at The New York Clinical Society in New York. Dr. Selesnick also served as a visiting professor at the University of Cincinnati and the Medical University of South Carolina; and as a panelist at the Sixth International Conference on Acoustic Neurona and Other Cerebellopontine Angle Tumors, Los Angeles.

Michael G. Stewart, MD, MPH, was visiting professor and keynote speaker at resident graduations at Georgia Health Sciences University, Johns Hopkins University, Vanderbilt University, and the University of Iowa; visiting professor at Georgetown University and Baylor College of Medicine; invited speaker at the Washington Metro Otolaryngology Society, Salzburg Weill Cornell Seminar, Salzburg, Austria, and OMI Otolaryngology Seminar, Pavlov State Medical University, St. Petersburg, Russia; and Guest of Honor, Annual Rhinology and Advanced Sinus Surgery course, Department of Otolaryngology, Third Affiliated Hospital of Sun Yat-Sen University, Guangzhou, China.

Lucian Sulica, MD, was an invited speaker at the International Voice Symposium at New York University, the Robotic and Laser Surgery in Otolaryngology course in Hackensack, NJ, and the keynote speaker at the Australia-Asia-Pacific Laryngology & Dysphagia Conference in Melbourne, Australia; and was the Elbyrne Gill lecturer at the Virginia Society of Otolaryngology-Head & Neck Surgery Annual Meeting.

Honors and Awards

Ashutosh Kacker, MBBS, received an Honor Award from the American Academy of Otolaryngology-Head and Neck Surgery.

David I. Kutler, MD, was inducted as a Fellow in The Triological Society.

Vikash K. Modi, MD, was awarded the Malcolm Schvey Clinical Teaching Award in June 2012 from Weill Cornell Medical College.

Joseph J. Montano, EdD, received a Service Recognition Award from the Hearing Loss Association of America – the nation’s leading organization representing people with hearing loss.

William R. Reisacher, MD, was an Honor Award recipient of the American Academy of Otolaryngology-Head and Neck Surgery.
Samuel H. Selesnick, MD, was presented with the Vice Presidential Citation by The Triological Society in recognition of outstanding contributions to the Society.

Michael G. Stewart, MD, MPH, received the 2012 Distinguished Service Award (2nd award) from the American Academy of Otolaryngology-Head and Neck Surgery, and was inducted into the Alumni Hall of Honors of St. Xavier High School, Louisville, KY.

Leadership Appointments

David I. Kutler, MD
President, New York Head and Neck Society

Kate E. McCarn, MD
Educational Committee, American Academy of Otolaryngology-Head and Neck Surgery
Task Force, New Materials, American Board of Otolaryngology

Joseph J. Montano, EdD
Board of Trustees, Hearing Loss Association of America

Thomas Murry, PhD
Advisory Board, Pan-European Voice Conference

Mukesh Prasad, MD
Chairman, Clinical Affairs Subcommittee of the General Faculty Council, Weill Cornell Medical College

William R. Reisacher, MD
Board of Directors, American Academy of Otolaryngic Allergy

Samuel H. Selesnick, MD
Chair, Subspecialty Advisory Council, American Academy of Otolaryngology-Head and Neck Surgery
Chairman, Nominating Committee, Council of Scientific Trustees, Hearing Health Foundation
Chairman, Committee on Applicants, Manhattan District #2, American College of Surgeons Secretary-Treasurer, Board of Directors, Otolaryngology and Neurotology Incorporated (parent corporation of the journal Otolaryngology & Neurotology)
Executive Council Member, American Neurotology Society
Executive Council Member, American Otological Society
Senior Examiner, American Board of Otolaryngology

Michael G. Stewart, MD, MPH
Vice Dean, Weill Cornell Medical College
Board of Directors, American Academy of Otolaryngology-Head and Neck Surgery
Council Member and Vice President, Eastern Section, The American Laryngological, Rhinological, and Otological Society
Consultant to Board of Directors, American Rhinologic Society
President, Association of Academic Departments of Otolaryngology-Head and Neck Surgery
Board of Directors, American Board of Otolaryngology
Course Director, Otolaryngology Symposium, Salzburg, Austria

Editorial Appointments

Kevin D. Brown, MD, PhD
Editorial Board, Otolaryngology and Neurotology

Ashtosh Kacker, MBBS
Editorial Boards: The Laryngoscope; American Journal of Rhinology

Thomas Murry, PhD
Editor, Voice and Communication Sciences, Plural Publishing
Editorial Consultant Board, Journal of Medical Speech-Language Pathology
Editorial Consultant, Journal of Voice
Editorial Reviewer and Consultant, Journal of Speech and Hearing Research

Samuel H. Selesnick, MD
Editorial Board, Otolaryngology and Neurotology
Editorial Review Panel Member, Otolaryngology-Head and Neck Surgery

Michael G. Stewart, MD, MPH
Editor-in-Chief, The Laryngoscope

Lucian Sulica, MD
Editorial Board, The Laryngoscope
Peer-Reviewed Articles


Selected Publications – 2011-2013

2012


2011


C ombining the resources of Weill Cornell Medical College and Columbia University College of Physicians and Surgeons, the joint Otolaryngology – Head and Neck Surgery Residency Training Program provides outstanding opportunities in clinical care, research, and academic medicine.

2011–2012 Teaching Awards
The Maxwell Abramson Teaching and Service Award
Jayde Steckowynch, MD
Columbia University College of Physicians and Surgeons
The Malcolm Schvey Clinical Teaching Award
Vikash K. Modi, MD
Weill Cornell Medical College
The W. Shain Schley Resident Teaching Award
Saral Mehra, MD
PGY-5

Further Training
Alyn Kim, MD – Facial Plastic and Reconstructive Surgery, University of Toronto, Canada
Alison Maresh, MD – Pediatric Otolaryngology, Children’s National Medical Center, Washington, DC
Saral Mehra, MD, MBA – Head and Neck Surgery and Microvascular Reconstruction, Beth Israel Medical Center, New York, NY
Roheen Raithatha, MD – Advanced Rhinology and Endoscopic Skull Base Surgery, NewYork-Presbyterian Hospital/Weill Cornell Medical Center, New York, NY

2012 Resident Graduates
Alison Maresh, MD
Roheen Raithatha, MD

2012–2013 New Residents
Jin Suk Calvin Kim, MD
Valeria Silva Merea, MD

In November 2012, Weill Cornell faculty collaborated with faculty from New York University School of Medicine and Albert Einstein College of Medicine to present the New York Advanced Rhinology and Sinus Surgery Course. The two-day comprehensive CME program featured distinguished guest faculty Seth Brown, MD, Clinical Assistant Professor, Department of Surgery, University of Connecticut School of Medicine, and Brent Senior, MD, Professor and Vice Chairman for Academic Affairs and Chief, Division of Rhinology, Allergy, and Endoscopic Skull Base Surgery at the University of North Carolina School of Medicine, Chapel Hill. The program attracted some 70 otolaryngologists, residents, and fellows.
First Prize
Saral Mehra, MD, MBA
PGY-5
Factors Predictive of Voice and Swallowing Complaints Following Anterior Approaches to the Cervical Spine

Second Prize
Jiovani Visaya, MD
PGY-3
Histopathological Effects of Balloon Dilation in a Live Rabbit Model

Third Prize
Roheen Raithatha, MD
PGY-5
Inter-Rater Agreement of Nasal Endoscopy for Chronic Rhinosinusitis

2012 – 12th Annual Residents Research Day

Named Lecture Program – 2012 Guest Faculty

The Department of Otolaryngology - Head and Neck Surgery hosts distinguished physicians who come to Weill Cornell to share their expertise through our named lecture programs. In 2012, these included:

James A. Moore Lecture
Herman A. Jenkins, MD
Professor and Chairman
Department of Otolaryngology - Head and Neck Surgery
University of Colorado Health Sciences Center

Dr. Robert W. Selfe Lecture
Ellen M. Friedman, MD, FAAP, FACS
Professor and Dr. Bobby R. Alford Chair in Pediatric Otolaryngology
Baylor College of Medicine
Chief of Otolaryngology Service
Texas Children’s Hospital

Fifth Annual New York City Pediatric Airway Symposium
Seth M. Pransky, MD
Clinical Professor of Surgery
University of California, San Diego
Director, Pediatric Otolaryngology
UC San Diego Health System

Seventh Annual Otolaryngology Update
October 24 - 25, 2013
New York City
For more information, please call (212) 585-6800 or email nypcme@nyp.org.
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New Physician Appointment

We are pleased to welcome our newest faculty member, Maria V. Suurna, MD, to the Department of Otolaryngology – Head and Neck Surgery. Dr. Suurna joins us from the New York University School of Medicine, where she was an assistant professor in the Department of Otolaryngology. Dr. Suurna brings training and expertise in the full range of otolaryngology – head and neck surgery, including chronic ear problems and surgery for thyroid disorders and head and neck tumors. She completed residency training at the University of Cincinnati, where she was the recipient of the Gerson Lowenthal Award for Outstanding Microsurgical Skills in Temporal Bone Dissection from the Cincinnati Society of Otolaryngology and Head and Neck Surgery and Department of Otolaryngology – Head and Neck Surgery. Dr. Suurna received a master of science degree in biology followed by her medical degree from the University of Indiana School of Medicine.
Weill Cornell Medical College, Cornell University’s medical school located in New York City, is committed to excellence in research, teaching, patient care, and the advancement of the art and science of medicine, locally, nationally, and globally. Physicians and scientists of Weill Cornell Medical College are engaged in cutting-edge research from bench to bedside, aimed at unlocking mysteries of the human body in health and sickness and toward developing new treatments and prevention strategies. In its commitment to global health and education, Weill Cornell has a strong presence in places such as Qatar, Tanzania, Haiti, Brazil, Austria, and Turkey. Through the historic Weill Cornell Medical College in Qatar, the Medical College is the first in the U.S. to offer its MD degree overseas. Weill Cornell is the birthplace of many medical advances — including the development of the Pap test for cervical cancer, the synthesis of penicillin, the first successful embryo-biopsy pregnancy and birth in the U.S., the first clinical trial of gene therapy for Parkinson’s disease, and, most recently, the world’s first successful use of deep brain stimulation to treat a minimally conscious, brain-injured patient. Weill Cornell Medical College is affiliated with NewYork-Presbyterian Hospital, where its faculty provides comprehensive patient care at NewYork-Presbyterian Hospital/Weill Cornell Medical Center. The Medical College is also affiliated with The Methodist Hospital in Houston, Texas. For more information, visit weill.cornell.edu.