



# Newsletter

Number 2 Volume 1  
Autumn 2008

## From the Secretary' Desktop:

As ASGO enters its third year it is appropriate to reflect on where we are today and how we have gotten there. ASGO began as a dream of Jerry Goldstein and George Gates who collected a number of other individuals to constitute a board for the organization. The organizational meeting was held at the AAO in September 2006, and shortly thereafter the organization was chartered as a non-profit organization based in Texas. Bylaws were adopted, and we were granted 501-3c status by the IRS. Jerry Goldstein assumed the presidency, George Gates the treasurer, and Karen Kost was appointed program chairman for our inaugural meeting which was held in San Diego in April 2007, the afternoon immediately prior to COSM. Jerry coordinated the meeting arrangements with the ACS, who were exceptionally supportive in assisting our fledgling organization. The meeting was a great success, with Andrew Monjan, chief of the neurobiology of aging branch at the National Institute of Aging, whose talk, entitled *Aging: Growing Healthy*, was an outstanding introduction to the science of aging. Jerry selected Dick Goode, who is well known to all otolaryngologists as Guest of Honor, and a number of invited speakers filled the 4 hour program with a wide range of topics on issues facing the practice of geriatric otolaryngology.

The Board made a number of significant decisions early in the history of the organization. The first of these was that fellowship would be open to *all boarded physicians* whose practices include the management of geriatric patients with otolaryngologic disorders. The second key decision was to strive to keep the cost of dues as low as possible – which was accomplished primarily by establishing the Society as a *paperless organization*. This goal was facilitated by Mike Johns who set up a website for ASGO [www.geriatricotology.org](http://www.geriatricotology.org). If you haven't looked at the website yet, stop reading now and log on! (Remember to come back and finish reading this newsletter.) The third key decision was to include the cost of meeting registration in with the dues, which were set at \$100 per year – a figure which we believe may be one of the lowest of any medical society.

The current dues-paying membership is less than 100, but ASGO is positioned for growth as the number of elderly who require management of otolaryngologic disorders expands dramatically in the next decade. Help us grow by distributing copies of this newsletter to your friends and colleagues – not only otolaryngologists, but also internists, geriatricians, neurologists, etc. And be sure to put our 2009 meeting on your calendar! A call for papers will be coming out in the next several months.

## Minutes of 2008 Business Meeting

The second annual business meeting of ASGO was held on April 30, 2008, immediately prior to the annual meeting. The mission of the society was reviewed, and the Board of Directors' goal of maintaining the Society as a inclusive and low cost organization was emphasized. In keeping with this goal, the beginning balance in the treasury was \$5,871.71 with a projected net balance of \$3,803.00 prior to the expenses of the current meeting. As the society is a 501-3c organization it can receive charitable contributions. After some discussion a fund-raising committee was appointed, to be led by Doctor Elliott Morgan from Birmingham.

Dr. Steven Parnes was elected unanimously to serve as President-Elect beginning in 2008. With the election of Dr. Parnes to President-Elect, there were two vacancies on the Board of Directors. Dr. Brian McKinnon, of Augusta Georgia and editor of the newsletter, and Dr. Joseph Carter from Cleveland were elected to serve in this capacity.

At the completion of the meeting Dr Karen Calhoun of Columbia, Missouri assumed the presidency of the society for a two year term.

**The 2009 annual meeting will be held on Tuesday, May 26, 2009, one day after Memorial Day and again the day prior to the start of COSM. It will be held at the JW Marriott, Desert Ridge in Phoenix, Arizona. We are currently negotiating with the resort to open the meeting room rate early for ASGO attendees, and to extend it back through the holiday weekend for those who which to arrive early.**

Dave Eibling, MD  
Secretary, American Society of Geriatric Otolaryngology

## ASGO 2nd Annual Meeting 30 April 2008

The Second Annual Meeting of the American Society of Geriatric Otolaryngology was held in Orlando, Florida, on 30 April 2008. The program was timely and thought provoking. A synopsis of select presentations and the Auditory Rehabilitation Panel is below.

### **Opening Remarks, Keynote, Guest of Honor, and Invited Speakers**

**Opening Remarks:** Dr Goldstein, President of the American Society of Geriatric Otolaryngology.

Dr. Goldstein, the president of ASGO, opened the meeting with several words of wisdom regarding the timeliness of the society and its increasing relevance and importance as a subspecialty of otolaryngology. 'Timing is everything'.

**Keynote Speaker:** Dr. Joe LoCicero - Interspecialty relationships: Why they are Critical in Geriatrics

Dr LoCicero introduced his talk with this statement: 'There's going to be more of us later...and it's time for surgical disciplines to dedicate themselves to the care of the elderly'. Other disciplines are developing fledgling geriatric subspecialties. Within this context, the 'Specialists Initiatives' has set forth the following goals for geriatric societies : nurture leadership, develop curriculum and training materials, support educational symposia and research and support senior investigator awards. We have a responsibility to "teach – test – maintain" with both our colleagues and residents. There is already an existing body of knowledge on which we can build, and each society can customize its own teaching methods. Several geriatric-oriented research questions have been asked across the specialties and require answers. Dr. LoCicero used the 'Aerodigestive Service' as an example of a multidisciplinary service dedicated to the care of geriatric patients. This service includes surgeons from several specialties (Otolaryngology, Thoracic, General Surgery, Head and Neck Surgery) physicians from medical fields (Gastroenterology, Cardiology), as well as the services of paramedical disciplines (nurse practitioners, Speech-Language-Pathology, and the Shortness of Breath service. The service also trains fellows and residents. Dr. LoCicero stressed the value of a simulation center to train residents in various clinical techniques such as bronchoscopy. Dr LoCicero ended his inspiring talk with the following pearls: 'geriatric surgery has arrived, and societies such as ASGO are at the forefront of the movement'. We have a responsibility to share our knowledge and insights, and to collaborate with each other as well as with our medical and surgical colleagues.

**Guest of Honor:** Dr Frank Lucente - Ethical challenges in geriatric otolaryngology

Dr Lucente began by saluting Dr. Jerry Goldstein for his foresight and hard work in developing ASGO, and continued by pointing out that 'All of us will age, it is a natural process from which we cannot escape'. Dr. Lucente noted three ethical principles which must guide us: beneficence, autonomy, justice. These principles are challenged in geriatric care, as they are neither easy nor straightforward; ambiguities must be clarified and guidelines developed. Care of the elderly is very time-consuming and complex with multiple co-existent morbidities or issues. In many ways, the office examination of the geriatric patient has much in common with that of the pediatric patient: information must be retrieved from family members, elder abuse must be ruled out, and the clinician must appropriately interpret and assess goals. There are many examples of the difficult questions in elderly care; when is it appropriate to perform a tracheostomy? Should we force-feed the demented? Where do we draw the line between active care and palliation? Adding further complexity to the situation are the cultural issues to which we must be sensitive in treating elders. Disease, disability and death are experienced in many different ways across cultures and it is difficult if not impossible to provide unified cross-cultural guidelines.

As longevity continues to increase, so must access to care. One of the greatest challenges is providing access to care within the Medicare system for the elderly. The economics of medicine force physicians to be businessmen, and insurance status impacts care provided. In providing care for the geriatric patient, we should consider advice from Maimonides: ‘...sometimes give your services for nothing, calling to mind a previous benefactor who did so for you’.

Dr. Lucente concluded that ultimately the patient is the best teacher, and we must look to organizations such as this one for guidance in addressing the many complexities of elderly care.

## **Invited Speakers**

### Research in Geriatrics

Dr. Wen G. Chen

Dr. Chen began by highlighting the mission of the National Institute of Aging (NIA), which is to support and conduct research geriatric-related issues, including, amongst others, hearing loss, hyposmia/anosmia, Parkinsons’s and Alzheimer’s.

Hearing loss: Compared to those aged 48-59, hearing loss doubles in the 60-69 age group and triples in the 70-79 age group. Currently there is bench research on risk factors leading to hearing loss using neuroimaging studies, the study of psychophysical and electrophysiological changes, and investigations into genetic associations. The NIA is also involved in translational research pertaining to the eventual management of hearing loss using a sort of ‘bionic ear’ as well as new approaches with stem cells. Hearing loss in the elderly may be associated with Alzheimer’s disease. In particular, the central auditory processing deficit may be key to the early diagnosis of Alzheimer’s. Senile plaques are frequently identified in the high brain.

Hyposmia/Anosmia: Compared to the 50-50 age group, the prevalence of hyposmia/anosmia is three times higher in the 60-69 age group, and doubles for every decade thereafter. There is a slight male preponderance for all age groups. Interestingly, it is often unrecognized by patients, and, like hearing loss, is often associated with Alzheimer’s disease. A low odor score is associated with cognitive impairment, specifically impaired memory and processing speeds. Pathologically, neurofibrillary tangles and Beta-amyloid deposits are identified in the olfactory bulbs.

### The Imminent Crisis in Geriatric Medicine

Dr. D.E. Eibling, University of Pittsburgh

Doctor Eibling, ASGO secretary, reviewed the recent Institute of Medicine report on geriatric care in the United States, *Retooling for an Aging America – Building the Healthcare Workforce*. He emphasized the imminent nature of the crisis by quoting Doctor. Fineberg, IOM president, who stated in his forward to the report that *although the pending crisis (had) been predicted for years, we are now on the cusp of this change*. Dr Fineberg went on to point out that it is already too late to prevent the crisis; rather we must seek strategies to reduce its impact on the health of older Americans. Dr Eibling then reviewed the factors leading up to the crisis, both the anticipated dramatic increase in the number of older Americans as well as the precipitous drop in the number of care-givers who will be available to care for these older Americans. (The IOM estimates that by 2030 the shortage of physicians trained in the treatment of older adults will exceed 28,000.) The only viable solution to the impending crisis is to train specialists to tailor their practices to meet the needs of the geriatric patient, precisely the mission of ASGO! Dr

Eibling reported on a number of specific recommendations of the IOM and how ASGO members might respond to these recommendations.

## **AUDITORY REHABILITATION PANEL FOR PRESBYCUSIS**

Chair: Dr. G. Gates

Panel: Don Morgan, PhD. Los Angeles, CA. President of Hearing Resource Group, Inc :on-site management of hearing centers based in ENT-practice settings; Patricia Kricos, PhD. Professor of Communication Sciences & Disorders, U. Florida, Gainesville; Brad Volkmer, MBA – President of Epic Hearing Healthcare. Los Angeles

Dr Gates opened the panel by pointing to the fact that we all age, and along with the aging experience, comes the hearing loss of aging, presbycusis. Presbycusis has a predictable pattern both in diagnosis and in rehabilitation. A process that is both central and peripheral in its dysfunction, education, counseling and auditory training is as much a part of addressing presbycusis as amplification. This most common of disabilities will increase the demand for services, services that presently physicians often “give away”. He advocated a move towards a team approach to this growing population in order to address its needs.

Dr Morgan discussed the importance of physicians and audiologists of understanding their hearing practice, and the role that practice has in improving not only their patient’s satisfaction, their clinical and financial satisfaction as well.

Mr Volkmer discussed the role that Epic Hearing Healthcare is in providing a Hearing Service Plan, by addressing the concerns and needs of employers, patients, audiologists and physicians to improve access to hearing assessment and amplification.

Dr Kricos discussed the role and benefits of auditory training, describing for the audience the LACE training system. LACE, an acronym for Listening and Auditory Communication Enhancement, benefits the patient by teaching them behavioral strategies to enhance the comprehension of spoken language. Computer based and individualized, LACE’s refinement of listening skills, combined with amplification, provides much improved communication than amplification alone could provide.

## **FREE PAPERS**

### Transnasal Esophagoscopy: Safety and patient tolerance in the geriatric patient

T. O’Brien, K Parham, Farmington, Connecticut

GI symptoms such as dysphagia are common symptom in the elderly. Approximately 20% have GERD and there is an increased incidence of hiatal hernia and Barrett’s esophagus. The traditional screening tool for these conditions, esophagogastroduodenoscopy (EGD), requires sedation and can be rarely associated with serious cardiopulmonary complications. TNE may be an attractive alternative since it can be performed with local anesthesia only. In a retrospective review of 39 patients > 65 undergoing TNE for LPR, GERD or dysphagia, O’Brien et al found noted a complication rate as low as that found in a younger group. Complications were minor, consisting of epistaxis, light-headedness and unsuccessful procedure. These results are consistent with those in the literature and support TNE as a safe, well-tolerated diagnostic tool in patients over the age of 65.

### Geriatric Thyroidectomy: The safety of Thyroid Surgery in an Aging Population.

M.W. Seybt, D.J. Terris, Augusta, Georgia

Dr. Terris began by stating that thyroid surgery has become less invasive in the past 10 yrs as a result of the following changes: 1. Neck extension is no longer required, 2. Subplatysmal flaps are not elevated, 3. The upper pole is ligated as a single bundle, 4. Skin sutures can be replaced by Dermabond, and 5. The use of clips and drains is no longer necessary. As a result of these changes, thyroidectomy using the harmonic device can often be performed as an outpatient procedure. Thyroidectomy in patients >65 versus a younger group between 21 and 35 years of age was compared in a retrospective study. Patients >65 were more likely to have malignant disease and to require admission (probably because of co-morbidities). Of note, the incidence of permanent hypocalcemia and vocal fold paralysis was not increased in the geriatric population. In conclusion, Thyroid surgery using less invasive techniques is safe in patients over 65 years of age.

### Polypharmacy in the elderly

M. Fato, Pittsburgh, Pennsylvania

Dr. Fato began by highlighting the problem of polypharmacy. In the US, adverse drug reactions (ADEs) are responsible for >10,000 deaths/year. Approximately 30% of hospital admissions are linked to medications or ADEs. Polypharmacy is a huge problem in the elderly and is defined as >5 drugs, or the use of more medications than indicated in a particular individual. The 'pill burden' is the number of pills/tablets/capsules used daily. Compounding this problem is the fact that the elderly not only use more drugs, they use expired drugs, other people's drugs, and over 70% also use vitamins and herbs. The risk of ADEs is directly related to the number of drugs used, and increases exponentially with each added drug. ADEs in the elderly may in fact simulate some signs or symptoms of old age, such as confusion, falls, and dizziness, to name a few.

Pharmacokinetics in the elderly are altered by the following factors: decreased lean body mass, an increased percentage of body fat, and finally, reduced liver metabolism and renal blood flow. The "BEERS" criteria, an expert consensus, provides criteria used for prescribing medications in patients >65 and cautions against the use of certain classes of medications, such as benzodiazepines and anticholinergics. Dr. Fato also discussed non-compliance in the elderly, which may be linked to any of the following factors: the use of too many drugs, the cost of drugs, frequent dosing, ADEs, inability to read or open the container, and cognitive impairment. In order to help prevent these problems, the following basic guidelines should be used: use single daily dose drugs, be aware of drug interactions, use generic brands to control cost, and provide detailed written instructions with prescriptions. Dr. Fato concluded with this advice: 'start low, go slow, and avoid and /or discontinue drugs of questionable benefit.

### Cochlear Implant Performances in Older Patients

P. Roehm, D. Coehlo, B. Birenberg, S. Waltzman, New York, New York

A large number of elderly patients suffer from severe to profound sensorineural hearing loss (SNHL). Furthermore, hearing loss progresses more rapidly in this group. Consequently

there is a large demand for rehabilitation which comes in 2 principal forms: hearing aids and cochlear implants (CI). The latter is reserved for patients in whom hearing aids are not helpful. Factors specific to the elderly which increase the challenge of successful cochlear implantation include: 1. reduced cell count at the level of the spiral ganglia, 2. reduced brain volume, cognitive function and memory, and 3. compromised central auditory processing capabilities. This reduced central plasticity in the elderly raises the question as to whether CIs are as successful in the elderly. A retrospective review of multichannel CI in patients with idiopathic SNHL compared patients over 70 years of age with younger patients. The following results were noted: 1. all older implanted patients showed significant benefit following CI, but the improvement leveled off after 3 months to a year, compared to younger patients who continued to improve, 2. implanted elderly patients had improved quality of life scores, and 3. Those with right-sided implants had better speech outcomes than those with left-sided implants.

### Research in Geriatrics

Wen G. Chen, Ph.D

Dr. Chen began by highlighting the mission of the National Institute of Aging (NIA), which is to support and conduct research geriatric-related issues, including, amongst others, hearing loss, hyposmia/anosmia, Parkinson's and Alzheimer's.

Hearing loss: Compared to those aged 48-59, hearing loss doubles in the 60-69 age group and triples in the 70-79 age group. Currently there is bench research on risk factors leading to hearing loss using neuroimaging studies, the study of psychophysical and electrophysiological changes, and investigations into genetic associations. The NIA is also involved in translational research pertaining to the eventual management of hearing loss using a sort of 'bionic ear' as well as new approaches with stem cells. Hearing loss in the elderly may be associated with Alzheimer's disease. In particular, the central auditory processing deficit may be key to the early diagnosis of Alzheimer's. Senile plaques are frequently identified in the high brain.

Hyposmia/Anosmia: Compared to the 50-50 age group, the prevalence of hyposmia/anosmia is three times higher in the 60-69 age group, and doubles for every decade thereafter. There is a slight male preponderance for all age groups. Interestingly, it is often unrecognized by patients, and, like hearing loss, is often associated with Alzheimer's disease. A low odor score is associated with cognitive impairment, specifically impaired memory and processing speeds. Pathologically, neurofibrillary tangles and Beta-amyloid deposits are identified in the olfactory bulbs.

### Skin Testing for Allergy in the Elderly

Dr. K. Calhoun, Columbia, Missouri

Traditional wisdom holds that the elderly are not as prone to allergy-related problems as middle-aged adults and children. Several prick tests support this premise. However, changes in the elderly such as atrophic skin with fewer reactive cells may alter skin testing results. At the University of Missouri, 203 skin test results in patients between 20 to 40 years of age were compared to an older cohort over the age of 65. The results suggest that it takes a greater stimulus to elicit skin responses in older adults, but the incidence of allergic symptoms and positive intradermal tests is equal in both groups.

## News & Notes

**In AMA GME e-Letter:** For Physicians, Geriatric Care Is Everyone's Job.

A shortage of physicians with training and expertise in geriatrics, combined with a proposed 10 percent cut in Medicare physician payments, could limit access to quality health care for the growing ranks of the nation's elderly.

The U.S. health care work force is "too small and woefully unprepared," according to a new Institute of Medicine report entitled "Retooling for an aging America: Building the health care workforce." For that reason, notes AMA board member Cecil B. Wilson, MD, "All physicians caring for aging patients need to become proficient in geriatric care."

Read more <<https://mail.upmc.edu/exchweb/bin/redirect.asp?URL=http://www.ama-assn.org/ama/pub/category/18452.html>> on this and other issues in graduate medical education (GME) in the May issue of the AMA GME e-Letter.

### --Call for Papers--

**The American Medical Directors Association**, the professional association of medical directors, attending physicians, and others practicing in the long term care continuum, is dedicated to excellence in patient care and provides education, advocacy, information, and professional development to promote the delivery of quality long term care medicine. The Program Committee invites you to submit abstract proposals for AMDA's 2009 Annual Symposium, March 5–8, in Charlotte, North Carolina.

The program is designed for medical directors, attending physicians, nurses, administrators, consultant pharmacists and other long term care professionals. Medical students, interns, residents and fellows planning a career in geriatrics are also encouraged to attend. Suggested topics are emerging clinical information, best practices in management and medical direction, research, innovations in non-pharmaceutical modification of challenging behaviors, and updates on approaches to regulatory compliance, are areas of interest. For more suggestions on topics, please visit the submission site at <http://amda2009.abstractcentral.com>. While the deadline for Oral Presentation has passed, the deadline for Poster Presentations is October 1, 2008.

### --Call for Papers--

The 19th IAGG World Congress of Gerontology and Geriatrics, meeting in Paris, France, 5-9 July 2009, has announced its call for Abstracts!

The Call for Abstracts is open - Deadline: 31 January 2009

The Scientific Committee invites delegates to submit abstracts (for oral and poster communications) to be presented at the congress. The deadline for submission is January 31, 2009. The congress program is primarily organized around four main themes:

- \* Biological sciences
- \* Health sciences / Geriatric Medicine
- \* Behavioral and social sciences
- \* Social research, policy and practice

The abstract must address scientific issues around a coherent theme of interest to a broad audience.

Each oral communication session will have four to six speakers for a total of 60 to 90 minutes. Posters will be presented during the poster sessions. All speakers/presenters are required to register and pay the registration fee.

For more information please visit following web page: <http://www.gerontologyparis2009.com>

***Don't Forget!!***

**American Society of Geriatric  
Otolaryngology**

***Please Pay your 2008 Dues***

***ASGO is one of the last great bargains!***

***\$100 includes Meeting registration***

**Pay online with PayPal **or** Send Check to:**

**David Eibling MD Secretary, ASGO**

**200 Lothrop Street**

**Suite 500**

**Pittsburgh PA 15213**

***Pay online at***

***[www.geriatricotolaryngology.org](http://www.geriatricotolaryngology.org)***

***If you pay online notify me via email so I can assure you are credited !***