



Society of Physician Assistants in Otorhinolaryngology-Head & Neck Surgery

THE VANGUARD



President's Message

By Jose C. Mercado, PA-C, MMS, DFAAPA, CPAAPA

Over the last 18 months we have faced obstacles and challenges to our profession and even our livelihood. How we handle these moments of stress can determine our future success. When the COVID-19 pandemic started encroaching on our daily lives we had two choices; let it overwhelm us or fight to return to some semblance of normalcy. Failure was never an option.

When it became evident that there was no way for our members to safely attend the 2020 ENT for the PA-C in California, our CME Committee, led by Laura Kirk, Nabilah Ali and Trina Sheedy were quick to respond and successful reschedule to a virtual meeting in 2021. This averted a potentially devastating financial loss to SPAO while continuing to provide our members with the quality CME they have come to expect from our meetings. We are on track for another successful meeting April 2021.

At the same time, we were all witness to the tragic loss of life, personal hardship as well as social and economic crisis. Many of us were dealing with the increased stress from changes in our work environment. Clinic hours were shortened and, in some cases, even cancelled as staff and colleagues fell ill to the Corona Virus. Many of us continued to see patients and provided needed care. I know several friends that lost their jobs or had to relocate due to the pandemic. The financial and emotional burden was incredibly stressful as we sought ways to cope.

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THE VANGUARD

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Clinical Practice Guideline: Ménière's Disease

From the *AAO-HNS Bulletin*, April 2020 - Vol. 39, No. 3

Adapted from the April 2020 Supplement to Otolaryngology–Head and Neck Surgery. Read the guideline at otojournal.org.

Ménière's disease is a clinical condition defined by spontaneous vertigo attacks, each lasting 20 minutes to 12 hours, with documented low- to mid-frequency sensorineural hearing loss in the affected ear before, during, or after one of the episodes of vertigo. Prevalence estimates as low as 3.5 in 100,000 and as high as 513 in 100,000 have been reported from Ménière's disease studies worldwide.



“Ménière's disease has a lot of factors and can be mimicked by other illnesses. To add to that, it is an episodic disease that can take months, or even years, to diagnose,” said Gregory J. Basura, MD, PhD, Chair of the Guideline Development Group (GDG). Meredith E. Adams, practice MD, and Ashkan Monfared, MD, served as Assistant Chairs, and Seth R. Schwartz, MD, MPH, served as Methodologist.

To improve the diagnostic workup and treatment outcomes for Ménière's disease, this clinical guideline (CPG) used the best available published scientific and/or clinical evidence to enhance diagnostic accuracy and appropriate therapeutic interventions (medical and surgical), while reducing unindicated diagnostic testing and/or imaging.

“The guideline aims to reduce the subjectivity of diagnosis and treatment for Ménière's disease and to provide some objective standards based on the literature available today,” said Dr. Basura. “This new CPG gives providers some optimal tools with which to make their clinical decisions.

The guideline discusses the background on possible causes of Ménière's disease, disorders that present similarly to it, and the ways in which the disease can

progress. Due to the variability in clinical presentation in patients with definite and probable Ménière's disease, it is important to note that it may take many months to make a full and accurate diagnosis of the disease.

Ménière's disease is almost exclusively reported in adults, with less than three percent of cases estimated to occur in children younger than 18 years. The disease is most prevalent between ages 40 to 60 years, with peak onset in the 40s and 50s. In many patients, the most detrimental decline in hearing and balance function occurs within the first decade of diagnosis, yet patients continue to

have long-standing deficits that make Ménière's disease a chronic disease.

GUIDELINE KEY ACTION STATEMENTS (KAS)

KAS1: Diagnosis of Ménière's Disease

(recommendation)

Clinicians should diagnose definite or probable Ménière's disease in patients presenting with two or more episodes of vertigo lasting 20 minutes to 12 hours (definite) or up to 24 hours (probable) and fluctuating or non-fluctuating sensorineural hearing loss, tinnitus, or pressure in the affected ear, when these symptoms are not better accounted for by another disorder.

KAS2: Assessing for Vestibular Migraine

(recommendation)

Clinicians should determine if patients meet diagnostic criteria for vestibular migraine when assessing for Ménière's disease.

KAS3: Audiometric Testing

(strong recommendation)

Clinicians should obtain an audiogram when assessing a patient for the diagnosis of Ménière's disease.

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Lessons from 2020: An Inside Look Into Virtual Conference Planning

Nabilah Ali, PA-C, SPAO-HNS CME Committee Chairperson

I was elected CME chair in 2019. I was excited for the honor and was ready for the challenge—or so I thought. COVID-19 became a pandemic and 2020 became an unprecedented year for our democracy, economy, and society. Also unprecedented for the CME committee was planning our first ever virtual conference. This was a huge learning curve for me, but I am proud of the CME opportunity that we have created.

The Society of PAs in Otorhinolaryngology, Head and Neck Surgery (SPAO-HNS) has been well recognized for more than 10 years for our in-person conferences and hands-on workshops. The excitement of seeing old friends and meeting other colleagues from various ENT communities across the nation makes the work and preparation leading up to our annual CME conference extremely worthwhile.

At the beginning of 2020, our CME Committee, with me as the new Committee Chair, was struck with the news that our in-person April 2020 conference might not be possible due to the increased cases of COVID-19 and restrictions on social gathering.

The disappointment and the uncertainty were palpable during our board meeting when we all knew that the only option was to postpone our 2020 conference. There were so many unknowns. How widespread would this pandemic be? What do we as ENT PAs need to do to help our patients and communities while protecting ourselves? How do we provide continued medical education while prioritizing the safety of our attendees? What would the medical conference environment be like in 2021?

With no answers to any of these questions, our SPAO-HNS CME Committee joined together and ventured

into uncharted waters—planning a virtual conference. We kept our focus on our mission to provide high quality education, training, and collaboration.



This year, SPAO-HNS, in partnership with AAPA (American Academy of Physician Assistants), continues to provide an exceptional training opportunity for APPs and physicians at the annual ENT for the PA-C educational meeting. Our 11th Annual meeting is April 23-24, 2021 and is hosted this year by the University of California, San

Francisco Department of Otolaryngology-Head & Neck Surgery. We chose to host a virtual meeting to provide up-to-date ENT education without allowing the COVID-19 pandemic to prevent us from reconnecting with each other.

Through this challenging time, SPAO-HNS has proven to be a resilient organization. Our volunteer board of directors continues to have open conversations about our society's future and growth. We remain focused and optimistic in our ability to host annual CME conferences, to promote the growth and development of PAs in ENT, and to facilitate and support APPs and physicians by organizing and disseminating high quality otolaryngology education. Our insights from 2020 have strengthened our society and will better us for the future.

The primary lesson that this CME Chair has learned is one of perseverance. Conference planning, like clinical practice, requires patience and determination. We take care of our members and conference attendees the way we attend to the needs of our patients: we listen, we plan, and we continually learn and grow.

Clinical Practice During the COVID-19 Era

Alexis Britton, PA-C, Vanguard Newsletter Editor

The COVID-19 pandemic has created a multitude of challenges for patient care in otolaryngology. Our specialty learned quickly that our own exposure to COVID-19 was high, being that we are clinicians who utilize aerosolized generating procedures when evaluating upper airway complaints.

Scott Saffold, MD Medical Director, Chesapeake Bay ENT, PC is one of the largest employers of physician assistants in otolaryngology in Virginia. Michael Parish Malone PA-C is a board certified physician assistant who has worked with Dr. Saffold for many years. Both share their experience about rapid changes made during the initial months of the pandemic.

Q: During the early months of the COVID-19 pandemic, most outpatient practices limited in-office care to urgent complaints. What factors were there that led to reducing specific services offered by your practice?



*Scott Saffold,
MD*

Dr. Saffold: As the seriousness of the COVID pandemic became apparent, we were faced with several considerations relevant to our ability to provide care to patients. First and foremost was my obligation to provide a safe environment for our staff and patients. As very little was known at that time about risk, we

decided to close the practice to physical encounters until we could ensure safety. In the interim, we offered telehealth visits to our patients. We embarked upon an extensive literature review and collaborated with colleagues in the specialty to formulate a mitigation strategy. We learned about patterns of spread and risks specific to Otolaryngology. On this basis, we implemented a protocol that enabled us to resume office visits on a limited basis. Additional time requirements associated with our new protocols reduced our availability to patients. Pre-procedure COVID testing further hampered our ability to see patients urgently. Finally, to reduce potential exposure of patients to

the hospital setting, surgery has been limited to more urgent conditions.

Q: What was your experience when the practice shifted to telemedicine as a primary way to deliver care? What role did the PAs in your practice play in providing uninterrupted care to patients?

Dr. Saffold: Our PAs were critical in triaging and temporizing the delivery of care until we could resume in-office evaluations. Telemedicine allowed us to maintain contact with our patients. There are specific challenges to the practice of Otolaryngology without a physical interaction with the patient.



*Michael P.
Malone, PA-C*

Parish Malone PA-C: What is most unique about an ENT provider is our ability to perform endoscopy procedures. Medical management and patient reassurance are advantages of telehealth; however, I believe there is nothing that can replace a physical exam and face to face patient encounter.

Q: What safe-guard measures took priority in determining when you could safely resume in-office aerosol generating procedures?

Parish Malone PA-C: Our practice was able to acquire N95 masks for staff as well as gowns, face shields, and eye protection. We also created a negative pressure exam room with installation of a HEPA air scrubber and HVAC unit.

Dr. Saffold: One of the key factors allowing us to resume potentially aerosol-generating procedures in the office was ensuring that patients were COVID-negative. Although we could use PPE to reasonably reduce risk to our staff, aerosolization of virus would put other patients at risk. For this reason, it was critical that we identify a rapid testing regime that was

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Clinical Practice During COVID-19 *(continued)*

sufficiently sensitive. We believe that this depended upon nasopharyngeal sampling for PCR testing. We identified a regional laboratory and developed a relationship with them such that we could depend upon 24-hour turnaround. Our office collected specimens and couriered them to the lab so that results would be available prior to patients' appointments the following day.

Q: Do you believe there are COVID-19 related changes that will remain in your practice beyond the pandemic? If so, what will they be?

Dr. Saffold: The COVID pandemic has been very disruptive to our practice. Although painful, it may have some positive impact on us in the future. Strategies we now utilize to reduce the risk of airborne transmission of disease were probably valuable prior to the pandemic and will certainly be relevant moving forward. I must admit that precautions such as masking and other forms of PPE will be continued. We will consider continued enhanced air cleaning after aerosol generating procedures, particularly for patients who are at risk of having airborne transmissible disease.

Q: Are there any challenges that led to the development of new skills?

Parish Malone PA-C: Of the multiple challenges I encountered, the use of telemedicine was the most enlightening. It opened my eyes to some positive attributes, especially when it comes to caring for patients in remote areas and patients in nursing homes.

Q: Are there any valuable lessons that you have learned from the COVID-19 pandemic?

Dr. Saffold: Perhaps the most important lesson to be learned from the pandemic is the importance of flexibility. The organizations that reacted most rapidly to the new environment are those that thrived. Although some of these changes have impacted the patient experience negatively, we communicated the reasons for these changes and found that patients were generally receptive. Although the pandemic is not over, I feel very confident that our willingness to embrace change has ensured the safety of our patients and staff.

Q: Any additional comments about your experience during the COVID-19 pandemic?

Dr. Saffold: I am proud of the response of our clinical team of physicians and PAs. We stopped on a dime, used data to drive our decision-making, and created a safe environment for our patients and staff. Our collaborative approach allowed us to make modifications as necessary and will facilitate needed responses to future challenges.

Q: What advice would you give to PAs that may be entering the field of otolaryngology during the COVID-19 pandemic?

Parish Malone PA-C: The future of PAs entering the workforce in otolaryngology will be challenging even for those who have been practicing for many years. The key advice I would offer would be to remain open minded and find adaptive ways to continue to see patients in an efficient and safe manner. The COVID-19 virus will have many subtypes develop, this is the nature of corona viruses. We as APPs must be safe and also provide excellent service to our patients in this ever-changing environment.

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COVID-19 Vaccine Update

Rian Rosen, PA-C

There has been an influx of information surrounding the different vaccines available for COVID-19 and as consumers of this information, it is sometimes hard to keep track of it all. Luckily, I'm here to help. Below are some of the more common questions people have pertaining to the vaccines. Information has been summarized from the Centers for Disease Control and Prevention.

How does the COVID 19 vaccine work?

Specifically, COVID-19 mRNA vaccines work by instructing the immune system cells to make a harmless piece of a spike protein. This specific spike protein is found on the surface of the virus that causes COVID-19. After the protein piece is made, the cell breaks down the mRNA and disposes of it. Next, the cell displays the protein piece on its surface. Our immune systems recognize the protein does not belong, and begins building an immune response by making antibodies. The benefit of mRNA vaccinations allows for protection against the virus without actually getting infected by the virus. The vaccine does not use inactivated virus, attenuated virus, or any other kind of virus.

COVID-19 viral vector vaccines work by using a modified version of a different harmless virus. In this case, the harmless virus is a version of the adenovirus. The modified version of the virus is called the vector. The vector enters an immune system cell and uses the cell's machinery to produce a spike protein, which is a piece of the virus that causes COVID-19. Similarly to the mRNA vaccines, the spike protein is then displayed on the surface of the cell. The display of the spike protein triggers the immune system to respond as if it were a "foreign invader." The end result is antibodies against the specific spike protein that is only found on the surface of the virus that causes COVID-19. Thus, if actually infected by COVID-19, antibodies have already been made against the virus and the immune system is capable of fighting off the disease.

What is the purpose of the vaccine?

The goal is to develop herd immunity, a specific percentage of people protected from the disease because they have already had the disease or because they have been vaccinated against the disease.

Herd immunity limits the spread of disease and protects those who cannot be vaccinated. It is a form of indirect protection that can occur when a sufficient percentage of the population has become immune to an infection through previous infection, vaccination or both. Since this is a novel virus there is no long term data on how long COVID-19 antibodies remain active. Researchers estimate 75 -80% of the population would need to be vaccinated before herd immunity kicks in and the infection rates start to go down.

What is the difference between the vaccines?

The different vaccines were tested under different parameters so it is difficult to conduct a head-to-head analysis of the three vaccines. However, some of the similarities and differences are highlighted in the chart on the following page.

What does the future of COVID-19 look like?

According to the CDC, a fourth vaccine will be available to the US, AstraZenica. AstraZenica is said to be 79% effective against symptomatic COVID 19 cases and 100% effective against hospitalization and death. Not all individuals in the US are eligible for vaccination at this time in the US. Additionally, of those who are eligible, some still decline to be immunized. Lastly, there are additional strains in which the vaccines may be less effective against. As the summer approaches there will likely be a decrease in the number of hospital-related COVID-19 cases, however this virus is a seasonal virus. The goal is to achieve winter herd immunity which will require a few key considerations.

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COVID-19 Vaccine Update *(continued)*

1. Maintain social distancing as much as possible, wear masks during peak transmission months, avoid large social gatherings if considered an “at-risk” individual.
2. Increase global vaccination efforts to get as many people vaccinated as quickly as possible.
3. Persistent modification of vaccines to accommodate the emerging variants. Strategies can be implemented to facilitate early detection of variants, and adapt current vaccines to new variants through booster injections.

Although the future is still unknown, we have come a long way this past year. I encourage everyone to stay optimistic! If this year has taught us anything, it is that life is too short to be anything but optimistic.

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	PFIZER-BIONTECH	MODERNA	JOHNSON & JOHNSON
Type of Vaccine	mRNA vaccine	mRNA vaccine	Adenovirus serotype 26 vector vaccine
Eligibility	16 and older	18 and older	18 and older
Number of Doses	2 doses 21 days apart	2 doses 28 days apart	Single dose
Number of persons hospitalized in trials	0	0	0
Vaccine Efficacy	95% effective after 2 doses	94.1% effective after 2 doses	66.3% effective after 14 days 65.5% effective after 28 days
Additional Information	Trials were based on evidence prior to new COVID strains in Britain, South Africa, and Brazil.	Trials were based on evidence prior to new COVID strains in Britain, South Africa, and Brazil.	Tested in an environment with COVID-19 variants circulating and during a time when cases were surging.

Ménière's Disease *(continued from page 2)*

KAS4: Utility of Imaging

(option)

Clinicians may offer magnetic resonance imaging (MRI) of the internal auditory canal (IAC) and posterior fossa in patients with possible Ménière's disease and audiometrically verified asymmetric sensorineural hearing loss.

KAS5: Vestibular or Electrophysiologic Testing

(recommendation against)

Clinicians should not routinely order vestibular function testing or electrocochleography to establish the diagnosis of Ménière's disease.

KAS6: Patient Education

(recommendation)

Clinicians should educate patients with Ménière's disease about the natural history, measures for symptom control, treatment options, and outcomes.

KAS7: Symptomatic Management of Vertigo

(recommendation)

Clinicians should offer a limited course of vestibular suppressants to patients with Ménière's disease for management of vertigo only during Ménière's disease attacks.

KAS8: Symptom Reduction and Prevention

(recommendation)

Clinicians should educate patients with Ménière's disease on dietary and lifestyle modifications that may reduce or prevent symptoms.

KAS9: Oral Pharmacotherapy for Maintenance

(option)

Clinicians may offer diuretics and/or betahistine for maintenance therapy to reduce symptoms or prevent Ménière's disease attacks

KAS10: Positive Pressure Therapy

(recommendation against)

Clinicians should not prescribe positive pressure therapy for patients with Ménière's disease.

KAS11: Intratympanic Steroid Therapy

(option)

Clinicians may offer, or refer to a clinician who can offer, intratympanic (IT) steroids to patients with active Ménière's disease not responsive to noninvasive treatment.

KAS12: Intratympanic Gentamicin Therapy

(recommendation)

Clinicians should offer, or refer to a clinician who can offer, intratympanic (IT) gentamicin to patients with active Ménière's disease not responsive to non-ablative therapy.

KAS13: Surgical Ablative Therapy

(recommendation)

Clinicians may offer, or refer to a clinician who may offer, labyrinthectomy in patients with active Ménière's disease who have failed less definitive therapy and have non-usable hearing.

KAS14a: Role of Vestibular Therapy for Chronic Imbalance

(recommendation)

Clinicians should offer vestibular rehabilitation/physical therapy for Ménière's disease patients with chronic imbalance.

KAS14b: Role of Vestibular Therapy for Acute Vertigo

(recommendation against)

Clinicians should not recommend vestibular rehabilitation/physical therapy for managing acute vertigo attacks in patients with Ménière's disease.

KAS15: Counseling for Amplification and Hearing Assistive Technology

(recommendation)

Clinicians should counsel patients, or refer to a clinician who can counsel patients, with Ménière's disease and hearing loss on the use of amplification and hearing assistive technology.

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Ménière's Disease *(continued)*

KAS16: Patient Outcomes

(recommendation)

Clinicians should document resolution, improvement, or worsening of vertigo, tinnitus, and hearing loss and any change in quality of life in patients with Ménière's disease after treatment.

The GDG consisted of 21 members who represented experts in advanced practice nursing, audiology, consumer advocacy, emergency medicine, family medicine, otolaryngology, otology and neurotology, otolaryngic allergy, neuroradiology, and neurology.

The CPG is intended for all healthcare providers in any setting who are likely to encounter, diagnose, treat, and/or monitor patients with suspected Ménière's disease. This includes emergency medicine, primary care, otolaryngology, neurology, audiology, and physical/vestibular therapy. The target patient for the guideline is anyone 18 years of age or older who has a suspected diagnosis.

The Ménière's disease CPG was created using the methods listed in Rosenfeld RM Shiffman RN, and Robertson P. Clinical Practice Guideline Development Manual, Third Edition A Quality-Driven Approach for Translating Evidence Into Action. Otolaryngol Head Neck Surg. 2013;148(1S):S1-S55. doi:10.1177/0194599812467004 (<https://journals.sagepub.com/doi/full/10.1177/0194599812467004>)

The full guideline and other resources are available at www.entnet.org/MDCPG and in Otolaryngology–Head and Neck Surgery as published at otojournal.org.

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Affirmation of Value:

American Academy of Neurology (AAN)

Disclaimer:

This clinical practice guideline is not intended as an exhaustive source of guidance for managing patients with Ménière's disease. Rather, it is designed to assist clinicians by providing an evidence-based framework for decision-making strategies. The guideline is not intended to replace clinical judgment or establish a protocol for all individuals with this condition and may not provide the only appropriate approach to diagnosing and managing this program of care. As medical knowledge expands, and technology advances, clinical indicators and guidelines are promoted as conditional and provisional proposals of what is recommended under specific conditions but are not absolute. Guidelines are not mandates. These do not and should not purport to be a legal standard of care. The responsible physician, based on all circumstances presented by the individual patient, must determine the appropriate treatment. Adherence to these guidelines will not ensure successful patient outcomes in every situation. The AAO-HNSF emphasizes that these clinical guidelines should not be deemed to include all proper treatment decisions or methods of care or to exclude other treatment decisions or methods of care reasonably directed to obtaining the same results.

President's Message *(continued from page 1)*

I sought ways to deal with the stress and focused on my priorities by establishing new routines and enjoying some simple pleasures. I reassessed my goals and priorities. Since I did not know what would happen in the distant future, I focused on my immediate goals – staying healthy and keeping my family safe. Initially, I felt overwhelmed by the news and information on social media so I began limiting it to only peer reviewed and reliable sources. My stress level decreased considerably when I reduced my news watching. I learned early in the military that it's important to have a routine after a traumatic event and find comfort in simple or relaxing activities. With my kids home schooling and my reduced work schedule, we started raising chickens and goats. Now that I have resumed my full schedule the family is enjoying the small farm and fresh eggs.

Additionally, I sought ways to stay involved with the profession from a distance. I was able to still deliver some of my ENT lectures to PA Programs via Zoom and continued to advocate for the PA Profession. On Behalf of SPAO, I was able to support two important issues to PA Practice; proposed 2020 Physician Fee Schedule that increases the utilization of PAs by aligning federal Medicare PA policy regarding supervision with state law as well as eliminating

unnecessary and burdensome scope of practice requirements for PAs under the Medicare program.

This will be my last article as President of SPAO and want the Board Of Directors to know that I am very proud of them and the way they actively supported and advanced our agenda. I wanted to personally thank them for all their hard work and dedicated service. We say goodbye to outgoing board members; Jen Brooks, Brigitte Shaw, Trina Sheedy and Brittany Gunville and say hello to some new faces.

For those of you who are new to working with a volunteer group such as SPAO-HNS, I want to assure you that you are in for a rewarding and worthwhile experience. You will be surrounded by some of the most talented and dedicated individuals you will ever have the privilege of being associated with.

Overall, as a group and a profession, I feel we faced these challenges to our profession and even our livelihood with resilience. We are overcoming this great tribulation together. I feel honored and privileged to have been a part of this group and encourage every PA reading this to get involved so we can continue making positive changes.

SAVE THE DATE

ENT for the PA-C 2021 Virtual Conference

April 23-24, 2021

Join us from the comforts of your home!

The program features lectures hosted by the Department of Otolaryngology – Head and Neck Surgery at the University of California, San Francisco with both Core and Advanced learning tracks.

- Obstructive Sleep Apnea
- Head and Neck Cancer
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