



AMERICAN HEAD AND NECK SOCIETY

ADVANCED TRAINING COUNCIL ***Fellowship Program Application***

Please complete this application in full and
forward the original and 4 copies
(including copies of all attachments)
and the \$2,000.00 application fee
to:

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BASIC INTRODUCTION FOR PROGRAM APPLICATIONS

It is acknowledged that contemporary management of head and neck tumors often requires a multidisciplinary approach to patient care. The application for a fellowship program should demonstrate educational opportunities to facilitate this end.

Knowledge and experience in radiation therapy and medical oncology can be achieved either on a patient-to-patient or block-time basis or a combination of both. The goal is to facilitate an educational experience in the disciplines to allow eventual participation in a multidisciplinary team.

A comprehensive approach to surgical care of the patient includes nutritional support, respiratory therapy, reconstruction, maxillofacial prosthodontics, and rehabilitation and is an indication of a comprehensive head and neck oncologic program. A major deficiency in the availability of these clinical factors may be a cause for disapproval. The surgical experience for the fellow should be adequate in volume and variety to provide a well-balanced training. Interaction with a concurrent jointly sponsored training program, especially residency programs, must be clearly defined. The clinical volume should be sufficient to meet the needs of such residency programs and the fellowship.

Education is the sine qua non of a fellowship program. Applicants must indicate didactic learning opportunities, which are or will be available to Phase III candidates to supplement personal reading and patient care activities.

The development of a fellowship program in Head and Neck Surgical oncology will be deemed most likely to succeed when integrated into existing training programs to enhance rather than compete for educational opportunities.

**AMERICAN HEAD AND NECK SOCIETY ADVANCED TRAINING COUNCIL
FELLOWSHIP PROGRAM APPLICATION**

NAME AND ADDRESS OF INSTITUTION APPLYING:

Name: **Oregon Health & Sciences University**
 Address: **Department of Otolaryngology – Head and Neck Surgery**
Section Head and Neck Surgery
3181 SW Sam Jackson Park Rd PV-01
 City, State, Zip: **Portland, OR 97239**

NAME AND ADDRESS OF FELLOWSHIP PROGRAM DIRECTOR:

Name: **Peter Andersen, MD, FACS**
 Address: **Department of Otolaryngology-Head & Neck Surgery**
3181 SW Sam Jackson Park Rd PV-01
 City, State, Zip: **Portland, OR 97239**

Number of Fellows requested per year: 1

Tenure of Fellowship: X 1 year 2 years

A. GENERAL HOSPITAL INFORMATION

1. Hospital(s): List your principal hospital(s) and all affiliated hospitals:

<u>Principal Hospital(s) Name</u>	<u>Total Beds</u>	<u>Total # OP Visits</u>	<u>Total Cancer Admissions</u>
OHSU University Hospital	534	69011	3079
Portland Veterans Affairs Medical Center	252	697886	33280

2. Approved Residency Programs:

	Own	Affiliated		Own	Affiliated
General Surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pathology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Otolaryngology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Diagnostic Radiology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Plastic Surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pediatrics	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Dental	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Therapeutic Radiology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medical Oncology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ophthalmology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Thoracic Surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neurosurgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>

3. Other related existing or proposed fellowships at your institution:

Skull Base Surgery	<input checked="" type="checkbox"/>	Plastic Surgery	<input checked="" type="checkbox"/>
Microsurgery	<input checked="" type="checkbox"/>	Surgical Oncology	<input type="checkbox"/>

4. The type of approval of cancer program by the American College of Surgeons:

None Provisional 3 year

B. FELLOWSHIP BASIC INFORMATION

1. Check clinical services available to fellowship program:

	Own	Affiliated
Otolaryngology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
General Surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Radiation Oncology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medical Oncology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Plastic Surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Microvascular Surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Dental Prosthodontics	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Speech Rehabilitation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>

	Own	Affiliated
Social Services	__X__	_____
Psychiatry	__X__	_____
Dietetics	__X__	_____
Neurosurgery	__X__	_____
Specialized Head & Neck Nursing	__X__	_____
Thoracic Surgery	__X__	_____
Data Collection – Statistics	__X__	_____
Surgical Pathology	__X__	_____
Vascular Surgery	__X__	_____
Immunology	__X__	_____

2. Multidisciplinary Activities:

Describe the referral pattern within your institution(s). Discuss the participation of the radiation oncologist and medical oncologist. Does each discipline see all head and neck cancer patients within the institution? Are there multidisciplinary weekly conferences or committees such as tumor boards? *(Use additional paper if necessary for this narrative)*

Weekly multidisciplinary tumor board is held throughout the year. The conference is led by head and neck surgery section and is attended by medical oncologists, radiation oncologists, head and neck radiologists, pathologists and endocrinologists. Head and neck surgery residents and fellow are expected to attend the conference, present cases and participate in the discussions. Cases are presented by all services; reviewed and discussed by all members of the multidisciplinary team. Treatment modalities are discussed and explored. Management recommendations are made based on the best practice guidelines and current evidence.

All head and neck oncology patients are evaluated by head and neck surgical oncology service. Many patients have their entire work up and management at OHSU by a multidisciplinary team. OHSU is a tertiary referral center covering the entire state of Oregon, southwest Washington, northern California, Idaho and Montana. Patients are referred from this vast area to head and neck surgery service. Referred patients will be discussed at the multidisciplinary tumor board. Surgical management of patients is entirely performed at OHSU. Patients will be referred to other services at OHSU as appropriate. Due to large referral area and OHSU's unique role in the region; a number of

patients will be managed in conjunction with their local providers for nonsurgical management such as adjuvant radiotherapy or chemotherapy.

3. Describe interdisciplinary surgical activities as they currently exist in the head and neck program:

Head and neck endocrine surgery, laryngology and head and neck reconstruction are all integrated parts of head & neck service at OHSU. This integration gives a unique advantage to our team. The entire care of patients is handled by the head and neck service. The fellow will have exposure to all aspects of surgical management within the department. Patients who will require complex reconstruction can be scheduled expeditiously. In addition, the head & neck service works closely with many different surgical services. Joint cases are routinely performed with neurosurgery, spine service, general surgery, facial plastics, otology and plastic surgery. Most endoscopic skull base cases are managed jointly with neurosurgery service. Patient who require local tissue transfer are managed by head and neck service and facial plastics as seen appropriate. Larger surgical defects which require free tissue transfer are addressed by microsurgical, reconstructive team, which is part of the head & neck service. There is a strong relationship between head and neck surgery and oral maxillofacial surgery service at OHSU. Patients who need dental extractions, prosthetics or more complex dental procedures are managed in conjunction with oral maxillofacial surgery service in an expedited fashion because of this collaboration.

The head & neck section has the primary responsibility for all head & neck oncology, reconstruction and laryngology patients. Patients who require participation from other disciplines of otolaryngology such as facial plastics, otology, rhinology and pediatrics are managed in conjunction with the respective services. Head and neck surgery acts as an active consultant in the management of joint cases with other services such as thoracic surgery, neurosurgery and medical oncology.

C. FELLOWSHIP PROGRAM RESEARCH INFORMATION

1. Is laboratory research in head and neck cancer carried out in the institution(s)?

Yes_____X_____ No_____

If yes, briefly describe program or projects including funding sources. List basic science peer reviewed oncology publications in the past three years.

Knight cancer institute is a recognized, NCI approved cancer center. Many laboratories in this center perform basic science research directly or indirectly related to head and neck oncology. During the one year program no dedicated time is allocated for basic science research. However, many otolaryngology residents within the department have worked and collaborated with multiple basic scientists at OHSU and there is established relationship between the two.

Bornstein S, White R, Malkoski S, Oka M, Han G, Cleaver T, Reh D, Andersen P, **Gross N**, Olson S, Deng C, Lu SL, Wang XJ. Smad4 Loss Causes Spontaneous Head and Neck Cancer with Increased Genomic Instability and Inflammation. *J Clin Invest.* 2009 Nov;119(11):3408-19.

2. Is clinical research in head and neck cancer carried out in the institution(s)?

Yes_____X_____ No_____

If yes, briefly describe all clinical studies ongoing or completed in the last two years. Please distinguish protocol from non-protocol studies. Describe the source of funding and list peer reviewed clinical publications in the past three years.

Clinical research has a very strong background at OHSU. Many important publications have come out of research conducted at the head & neck service. Head and neck service both conducts investigator initiated studies and participate in cooperative groups's trials. OHSU also has close collaboration with Portland VA medical center and participate in nationwide studies conducted through veterans administration.

1. RTOG 0234: A Phase II Randomized Trial of Surgery Followed by Chemoradiotherapy plus C225 (Cetuximab) for Advanced Squamous Cell Carcinoma of the Head and Neck (IRB #1364)

PI: John Holland. To evaluate, using a random assignment phase II design, two treatment regimens that utilize the EGFR inhibitor C225 in combination with chemoradiation in high-risk postoperative head and neck patients. The trial is designed to determine if either regimen is promising enough to be pursued in a subsequent phase III study. This decision will be primarily based on whether there is improvement in disease-free survival related to the RTOG database of similar patients treated with chemoradiation in the completed intergroup trial RTOG 9501.

2. RTOG 0522: A Randomized Phase III Trial of Concurrent Accelerated Radiation and Cisplatin Versus Concurrent Accelerated Radiation, Cisplatin and Cetuximab (C225) [Followed by Surgery for Selected Patients] for Stage III and IV Head and Neck Carcinomas (IRB #2826)

PI: John Holland. Evaluate whether the addition of cetuximab to a concurrent radiation-cisplatin regimen will improve progression-free survival in patients with locally advanced squamous cell carcinoma (SCC) of the oropharynx, hypopharynx, or larynx.

3. RTOG 0514: Establishment of a Head and Neck Cancer Tissue/Specimen Repository (IRB #2928)

PI: Neil Gross. To evaluate, using a random assignment phase II design, two treatment regimens that utilize the EGFR inhibitor C225 in combination with chemoradiation in high-risk postoperative head and neck patients. This trial is designed to determine if either regimen is promising enough to be pursued in a subsequent phase III study. This decision will be primarily based on whether there is improvement in disease-free survival related to the RTOG database of similar patients treated with chemoradiation in the completed intergroup trial RTOG 9501.

4. RTOG 0619: A Randomized Phase II Trial of Chemoradiotherapy versus Chemoradiotherapy and Vandetanib for High-Risk Postoperative Advanced Squamous Cell Carcinoma of the Head and Neck (IRB #5140)

PI: Neil Gross. To screen for an indication that the addition of vandetanib to chemoradiotherapy may prolong disease-free survival as compared to a combination of chemoradiotherapy in patients with resected, high-risk head and neck squamous cell carcinoma.

5. RTOG 0920: A Phase III Study of Postoperative Radiation Therapy (IMRT) +/- Cetuximab for Locally-Advanced Resected Head and Neck Cancer (IRB #6918)

PI: Neil Gross. Test whether the addition of cetuximab to radiation therapy will improve overall survival (OS) in postoperative patients with intermediate risk following surgery.

6. Phase I/II Study of Postoperative Adjuvant Chemoradiation for Advanced-Stage Cutaneous Squamous Cell Carcinoma of the Head and Neck (cSCCHN) (IRB #5466 & 6901)

PI: Neil Gross. To determine the MTD (maximally tolerated dose) of OSI-906 when used in combination with erlotinib and radiation therapy after surgery for advanced-stage cSCCHN. To estimate the 2-year overall survival (OS) compared to historical controls

7. Phase II Study of Tarceva (Erlotinib) as Adjuvant Treatment for Locally Advanced Head and Neck Squamous Cell Carcinoma, with Evaluation of Neoadjuvant Biomarker Modulation with Tarceva plus Sulindac (UPCI #05-045) (IRB #3540)

PI: Neil Gross. To assess the 3-year disease free survival of HNSCC patients treated with surgery, postoperative chemoradiation and long-term adjuvant Tarceva. To study the overall survival, disease recurrence and secondary primary tumor rates in this HNSCC population. To determine if biomarkers, some of which are known predictors of clinical outcome, can be modulated in HNSCC tumors by preoperative treatment with 7-14 consecutive days of Tarceva plus sulindac versus Tarceva alone. To assess if neo-adjuvant modulation of biomarkers can predict response to molecular targeted therapy and clinical outcome.

8. Comparison of Biomarker Modulation by Inhibition of EGFR and/or SRC Family Kinases Using Erlotinib and Dasatinib in Head and Neck and Lung Cancers (UPCI #07-124) (IRB #5096)

PI: Neil Gross. To determine the modulation of biomarkers by EGFR and/or Src targeting in head and neck and lung cancers. To determine if biomarker modulation is associated with reduction of tumor volume and/or evidence of histologic response in the tumor (e.g. decreased proliferation and/or decreased apoptosis) as well as safety and tolerability.

9. HOTSPOT Protocol: HPV Oral Transmission Study in Partners Over Time (IRB #5263)

PI: Neil Gross. Describe agreement in type-specific oral HPV infection in HPV-positive oropharyngeal cancer patients and their sexual partners. Evaluate factors associated with persistent and newly-detected oral HPV infection in partners (age, sexual behavior, marijuana, tobacco).

10. TALC Protocol: Observational Study of Swallowing Function After Treatment of Advanced Laryngeal Cancer (IRB #5833)

PI: Neil Gross. The immediate goals of this study are to compare the impact of primary chemoradiation versus surgery on patients with new tumors of the hypopharynx (T2, T3) and cartilage-invading larynx (T3, T4) that would require total laryngectomy for cure. These types of tumors have not been the focus of prior organ preservation trials.

The purpose of this observational cohort study is to:

- 1) Determine whether total laryngectomy leads to better self-reported swallowing in patients with advanced tumors of the hypopharynx and larynx,
- 2) Explore the relative impact of surgery versus chemoradiation on a number of secondary outcomes, including objective measures of speech and swallowing, as well as self-reported health status, Head and Neck (H&N) specific function, and speech,
- 3) Identify pre-treatment variables that predispose to poor swallowing function after treatment.

11. Venous Thromboembolism in Head and Neck Cancer Patients after Surgery (IRB #6640)

PI: Neil Gross. This is a pilot study to determine the incidence of lower extremity venous thromboembolism (VTE) in OHSU patients with head and neck cancer after surgery. Cancer patients undergoing major surgery are considered high risk for VTE. Despite the known association between VTE and cancer, there is no prospective data on the incidence of VTE among head and neck cancer patients undergoing surgical ablation. This study will allow OHSU investigators to determine whether or not the current standard for prevention of VTE (compression boots and frequent walks) is adequate for this patient population. Knowing this will allow OHSU physicians to make more accurate decisions about if and when to use anti-coagulative therapy after head and neck cancer surgery.

12. Nomogram Predictive of 10-year Mortality in Differentiated Thyroid Cancer (IRB #4072)

PI: Neil Gross. Confirm and quantify the association between predictor variable (age, sex, race, TNM stage, histology, and socioeconomic status) and 10-year cause-specific mortality in differentiated thyroid cancer cases from a historical cohort selected from the SEER national cancer registry. Develop a nomogram that will predict 10-year cause-specific mortality in differentiated thyroid cancer patients based on analysis of confirmed prognostic variables using SEER data. Internal validation of nomogram performance.

13. Transcriptome Analysis of Recurrent Head and Neck Squamous Cell Carcinoma: A Pilot Study (IRB #5886)

PI: Neil Gross. To analyze the evolution of gene expression in tumor epithelial cells and the surrounding microenvironment after prior treatment of HNSCC. To identify key changes in gene expression associated with recurrent HNSCC.

14. Outcomes of Patients Treated Surgically for Lymph Node Metastases from Cutaneous Squamous Cell Carcinoma of the Head and Neck (IRB #6165)

PI: Neil Gross. Lymph node metastases from cSCCHN is uncommon. Scant data exists on the outcome of this select group of patients. The purpose of this study is to compare the survival of patients treated surgically with or without radiation therapy for lymph node metastases from cSCCHN with patients without metastatic nodal disease, and to correlate survival and disease progression with the presence of cancer stem cells and expression of growth factor receptors.

15. Surgical Management of Invasive Fungal Sinusitis (IRB #6661)

PI: Neil Gross. To document the clinical presentation, surgical management and outcomes of patients with fulminant invasive fungal sinusitis.

16. Central Nodal Metastases in Papillary Thyroid Carcinoma Based on Tumor Histology and Focality (IRB #5412)

- PI: Neil Gross. To determine the risk of nodal metastases to the central neck compartment from PTC relative to known prognostic variables.

17. Retrospective Review of Airway Management in Autoimmune Laryngotracheal Stenosis (IRB #6672)

PI: Neil Gross. To assess surgical outcomes of patients treated for LTS caused by autoimmune diseases. To evaluate the safety and efficacy of airway reconstruction in patients with autoimmune LTS. To evaluate positive and negative predictors of outcome in patients treated surgically for LTS. To analyze the effect of oral immunosuppressant use on the frequency of surgical interventions in patients with autoimmune LTS.

18. Hypopharyngeal Reconstruction After Laryngectomy and Laryngopharyngectomy Following Concurrent Chemoradiation: A Multi-Center Review of Reconstructive Techniques, Complications, and Outcomes (IRB #6982)

PI: Mark Wax. To assess the types of hypopharynx reconstruction following failure of concurrent chemoradiation being used nationally, and their associated rates of pharyngocutaneous fistula formation, defined as a pharyngocutaneous fistula leading to reoperation, a hospital stay greater than 6 weeks, or death. To assess the major and minor complication rates of patients undergoing hypopharyngeal reconstruction following failure of concurrent chemoradiation. To assess the speech and diet outcomes of patients undergoing hypopharyngeal reconstruction following failure of concurrent chemoradiation. To assess the length of hospital stay for patients undergoing hypopharyngeal reconstruction following failure of concurrent chemoradiation.

19. Salvage surgery in Head and Neck Cancer (IRB #7180)

PI: Peter Andersen. To analyze the clinical and tumor-specific variables that predict prognosis following salvage surgery for HNSCC.

Pharmaceutical-sponsored studies:

1. Genmab 205: An open label single arm trial investigating zalutumumab, a human monoclonal anti-egf receptor antibody, in combination with best supportive care, in patients with non-curable squamous cell carcinoma of the head and neck who have failed standard platinum-based chemotherapy (IRB #3893)

PI: Neil Gross. To investigate zalutumumab in combination with BSC in terms of overall survival in non-curable patients with recurrent and/or metastatic disease who have failed after at least one course of standard chemotherapy.

2. Theradex Protocol: Phase I Trial of Intratumoral Administration of HF10, a Replication-Competent Herpes Simplex Virus Type 1, in Patients with Refractory Head and Neck Cancer (IRB #5265)

PI: Neil Gross. The objectives of this study are: to evaluate the safety and tolerability of HF10 when injected intratumorally and to determine the recommended dose for further studies; to characterize change in viral replication in whole blood, saliva, urine; to look for evidence of the overall and local antitumor activity; to assess viral replication and antitumor activity of HF10 in biopsy samples; and to evaluate the development of anti-HSV

antibodies following a single intratumoral injection of HF10 in patients with refractory head and neck cancer.

3. ImClone Protocol: Prospective, Longitudinal, Multi-Center, Descriptive Registry of Patients Receiving Therapy other than Surgical Resection Alone for Newly Diagnosed Head and Neck Carcinoma (IRB #3914)

PI: Neil Gross. The primary objective of the registry is to describe, in detail, patterns of care for head and neck carcinoma patients. Secondary objectives include: document outcome (tumor control, survival) by treatment regimen; determine the incidence and severity of major dose-limiting and other important treatment toxicities; identify supportive care received for managing nutrition, pain, nausea and other complications.

Funding:

2010-11 Transcriptome Analysis of Recurrent Head and Neck Squamous Cell Carcinoma.
Principle Investigator: Marcus Monroe, MD
OHSU Medical Research Foundation
\$20,000

2010-11 Inhibition of Epidermal Growth Factor Receptor and Insulin-like Growth Factor Receptor in Cutaneous Squamous Cell Carcinoma.
Principle Investigator: Daniel Clayburgh, MD, PhD
OHSU Medical Research Foundation
\$20,000

2009-11 Phase I/II Study of Chemoradiation in Cutaneous Squamous Cell Carcinoma.

AHNS/AAO-HNSF Surgeon Scientist Combined Award

\$75,000

Pending Support

2011-13 Venous Thromboembolism in Head and Neck Cancer Patients after Surgery
PI: Neil Gross, Triological Society Career Development Award
\$40,000

2011-14 Oral HPV Infection and Related Abnormalities in Highly Exposed Partners
Principle Investigator: Gypsyamber D'Souza, Ph.D.
NIH/NCI, R21

Peer reviewed Publications:

Givi B, Andersen PE: Rationale for modifying neck dissection.
J Surg Oncol. 2008 May 20;97(8):674-682,

Schuff KG, Weber SM, Givi B, Samuels MH, Andersen PE, Cohen JI: Efficacy of Nodal Dissection for Treatment of Persistent/Recurrent Papillary Thyroid Cancer. Laryngoscope. 118(5):768-75, 2008.

McCarn KE, Ghanem T, Tartaglia J, Gross N, Andersen P, Wax MK. Second Free Tissue Transfer in Head and Neck Reconstruction. *Otolaryngol Head Neck Surg.* 2008 Oct;139(4):525-9.

Lo JO, Weber SM, Andersen PE, Gross ND, Gosselin M, Wax MW. Atelectasis after Free Rectus Transfer and Abdominal Wall Reconstruction. *Head Neck.* 2008 Oct;30(10):1339-43.

Gross ND, Patel SG, Carvalho AL, Chu PY, Kowalski LP, Boyle JO, Shah JP, Kattan MW. Preliminary Nomogram for Deciding Adjuvant Treatment after Surgery for Oral Cavity Squamous Cell Carcinoma. *Head Neck.* 2008 Oct;30(10):1352-60.

Rossmiller S, Ghanem T, Gross N, Wax M. The Modified Ileocolic Free Flap: A Viable Choice for Reconstruction of Total Laryngopharyngectomy and Total Glossectomy. *Head Neck.* 2009 Apr;31(9):1215-19.

Monroe MM, Sauer DA, Samuels MA, Gross ND. Pathology Quiz: Conventional Mucoepidermoid Carcinoma of the Thyroid. *Arch Otolaryngol Head Neck Surg.* 2009 Jul;135(7):720-22.

Kekatpure VD, Boyle JO, Zhou XK, Duffield-Lillico AJ, Gross ND, Lee NY, Subbaramaiah K, Milne G, Lippman SM, Dannenberg AJ. Elevated Levels of Urinary Prostaglandin E Metabolite Indicate a Poor Prognosis in Head and Neck Squamous Cell Carcinoma Patients. *Cancer Prev Res.* 2009 Nov;2(11):957-65.

Gross ND. Temporary Hypocalcemia after Thyroidectomy: First, Know Thy Harm. *Head Neck.* 2010 Mar;24:283-4.

Gross ND, Ganly I, Patel SG, Bilsky MH, Shah JP, Kraus DK. Results of Anterior Skull Base Surgery in Pediatric and Young Adult Patients. *Skull Base.* 2010 20(2):75-81.

Salter KD, Andersen PE, Cohen JI, Schuff KG, Lester L, Shindo ML, Sauer D, Gross ND. Central Nodal Metastases in Papillary Thyroid Carcinoma Based on Tumor Histology and Focality. *Arch Otolaryngol Head Neck Surg.* 2010 Jul;136(7):1-5.

Nicky N, Thompson M, Rossmiller S, Gross N, White C, Gatter K. Diagnostic Pitfalls in Syringocystadenocarcinoma Papilliferum: Case Report and Review. *Arch Path Lab Med.* 2010 Aug;134:1205-09.

Gross ND, Shah JP. Salivary Gland Neoplasms. *Ann Oncol.* (in press)

Paulson L, Hamilton B, Hooper J, Gross N. Radiology Quiz: Cervical Foregut Duplication Cyst. *Arch Otolaryngol Head Neck Surg.* 2011 (in press)

Givi B, Anderesen PE, Diggs BS, Wax MK, Gross ND. Outcome of Patients Treated Surgically for Lymph Node Metastases from Cutaneous Squamous Cell Carcinoma of the Head and Neck. *Head Neck*. 2011

Monroe MW, McClean M, Gross ND. Infected Tracheal Diverticulum Presenting as a Cervical Abscess. *Otolaryngol Head Neck Surg*. 2011 (in press)

Varley CD, Gross ND, Marx DP, Winthrop KL. Tuberculosis of the Nasolacrimal Duct. *Ophthal Plast Reconstr Surg*. 2011 (in press)

Wang SJ, Wissel AR, Ord CB, Kalpathy-Cramer J, Fuller CD, Holland JH, Gross ND. Individualized Estimation of Conditional Survival for Head and Neck Cancer Patients. *Otolaryngol Head Neck Surg* (in press)

Miller MW, Vetto JT, Monroe MM, Weerasinghe R, Andersen PE, Gross ND. False Negative Sentinel Lymph Node Biopsy in Head and Neck Melanoma. *Otolaryngol Head Neck Surg* (submitted)

Thai L, Mc Carn K, Stott W, Watts T, Wax M, Andersen P, Gross ND. Venous Thromboembolism in Head and Neck Cancer Patients after Surgery. *Head Neck* (submitted)

3. Are there laboratory research facilities available to the head and neck fellow?

Yes No If yes, please describe.

Many laboratories at OHSU and Knight cancer institute have close collaboration with head and neck service and arrangements can be easily made for interested fellows to use these facilities in collaboration with primary investigators. Basic science research is not part of the initial curriculum for head and neck fellowship program however.

4. Describe the fellow's research program. Please note the following:

It is expected that all fellows will be involved in clinical research projects and participate in the presentation/publication of the results. It is recommended that fellows in 24-month programs should have dedicated (protected or block) time available for laboratory research.

Research is an integral part of head and neck surgery service activities. The fellows are expected to participate, collaborate and initiate clinical research during their tenure. The fellows will be mentored by faculty members in design and conduct of clinical research and IRB processing of new proposals. They will have access to OHSU cancer registry which is maintained by Knight Cancer institute and has patients' information for the past 30 years. In addition, OHSU works closely with Oregon cancer registry. These resources give prospective fellows ample data sources to study and analyze. The fellow is expected to conduct, complete, present and publish three clinical research projects during the course of fellowship. Guidance and mentoring is provided for the fellows by multiple members of faculty with established track records in each step of the process.

D. FELLOWSHIP EDUCATION INFORMATION

1. List all teaching sessions in which the fellow participates regularly.

Type of Conference	Frequency	Role of Fellow
OHSU Head & Neck Tumor Board	Weekly	Presentation, Discussion
Otolaryngology Grand Rounds Attendance	Weekly	Presentation,
Morbidity & Mortality Conference	Monthly	Presentation, Discussion
Otolaryngology Educational lectures	Weekly	Presentation, Discussion
Head & Neck Journal Club	Monthly	Selecting topics, Discussions

Tumor boards:

Head and neck oncology patients are presented by multiple disciplines at OHSU tumor board conference. Specifics of each individual patient are discussed by different members of multidisciplinary team. Available therapeutic options and clinical trials (if appropriate) are explored and recommendations are made. The fellow is expected to attend this conference, present cases and participate in discussions. The fellow is expected to be able to analyze and make therapeutic recommendation as he/she progresses through the training.

Otolaryngology Grand rounds:

This conference is held throughout the year. The fellow is expected to attend the appropriate lectures and other relevant topic to his/her interest according to the individual's interest. The fellow is also responsible to present two lectures during the year.

Morbidity & Mortality conference:

M&M conference is held monthly at the department level. The fellow is expected to attend the conference and discuss relevant cases. The fellow is expected to review each case thoroughly, explain the course of events, review related literature and make recommendation to improve management in appropriate situations.

Otolaryngology Educational lectures:

This conference is held weekly for residents. The fellow is expected to give two didactic lectures in head & neck related topics.

Journal Club:

Head & Neck journal club is held monthly. The focus of journal club is to discuss seminal articles, best evidence and recent developments in head and neck oncology. The fellow will select the topic and relevant articles. The fellow is responsible for guiding the discussion and conducting the session.

2. Describe the teaching responsibilities of the fellow.

The fellow has extensive responsibility in teaching residents and medical students. The fellow is expected to participate in residents' education during morning rounds and throughout the day as appropriate. The residents will report to the fellow with day to day developments of patients and it is expected that fellow is able to manage the patients and guide residents as appropriate. Inpatient consults and emergency room visits are presented to fellow by residents and the fellow with formulate the treating plan with faculty supervision. In appropriate level cases, the fellow has the responsibility to guide the residents though cases in the operating room. In more complex cases the fellow will participate in education of the resident during the operation.

In addition to day to day activities, the fellow will present two lectures at grand rounds and also give two educational lectures at resident conference.

3. What is the number of head and neck cancer patients evaluated by Phase III program last academic year:

TOTAL NUMBER EVALUATED: _____2022_____

Previously untreated patients: _____1626_____

Previously treated patients: _____

Consult only: _____

Number of patients treated surgically: _____

Number of patients treated non-surgically (XRT/Chemo): _____

Head and neck patients evaluated by Speech Pathology: _____ 1033 _____

Head and neck patients evaluated by Maxillofacial

Prosthetic Department: _____

4. Number of new patients for whom the fellow will have primary responsibility/yearly: _____ 1000 _____
- Total number of patients fellow will operate upon yearly either as primary surgeon or first assistant to a resident: _____ 200 _____
- Total number of major head and neck operations fellow will participate in either as primary surgeon or first assistant: _____ 300 _____
- Number of outpatient visits fellow will observe yearly: _____ 1000 _____

5. Will the fellow be assigned blocks of time in other departments?

Yes No

If yes, please describe briefly.

Due to design of head and neck section, the fellow has ample interaction with speech therapist and nutritionist while in the service. A one week block of time will be assigned for radiation oncology, medical oncology and endocrinology each. The fellow is expected to attend the clinics and day to day activities of each service during this time. The objective of these rotations is to familiarize the fellow with principles of radiation oncology (planning, simulation) Medical oncology (choice of different regimens) and endocrinology (endocrine management of head and neck endocrine patients). The fellow will be able to observe and participate in new patient consultations, selection of treatment plans, follow up and treatment assessments. Exposure to pathology and radiology is assured through tumor board and educational lectures throughout the year.

6. Indicate the number of oncologic cases performed in the previous 12 months by head and neck surgical teaching faculty, which would have been available to the fellow last year. Record according to category.

Salivary gland surgery:	104
Nose and paranasal sinus and skull base surgery:	122
Lip surgery:	9
Oral cavity surgery:	136
Neck surgery:	276
Larynx and pharynx surgery:	156
Thyroid and parathyroid surgery:	301
Tracheal surgery:	36
Ear and temporal bone surgery:	24
Regional/myocutaneous flaps:	160

7. Indicate total number of chief residents on the head and neck service at any one time with head and neck fellow: _____ 1 _____

Please explain:

There will be one chief resident with the fellow at each time. The head & neck team is consisted of one intern, one junior resident, one 4th year general surgery resident, one 4th or 5th year otolaryngology resident and head and neck fellow. The fellow is responsible for assignment of cases to each member suitable to their level of training. On each day of week at least two or three head and neck faculty are in the operating room and two have clinic. There is ample opportunity for each member of team to interact with faculty members and participate in operations and clinics.

E. FELLOWSHIP SERVICE INFORMATION

1. Give a narrative summary of clinical responsibilities during the fellowship:

The fellow's weekly responsibilities are the following:

- 1. Assign residents to cases, clinics appropriate to their needs, training level**
- 2. Lead morning rounds with residents. Discuss and formulate patient's treatment plan and relate relative information to the faculty members.**
- 3. Participate in surgeries with faculty members. Guide residents though parts of operation or less complex procedures.**
- 4. Participate in evaluation of patients in clinic**
- 5. Attend Otolaryngology grand rounds, weekly tumor boards. Present case, didactic lectures.**
- 6. Select articles for journal club and lead the monthly meetings.**
- 7. Evaluate inpatient and emergency room consults.**

The fellow will spend 1 to 1 ½ day in clinic. The fellow will work primarily with Dr. Maisie Shindo while on Endocrine service and Drs. Andersen and Gross during head and neck surgical oncology months. Other faculty members are closely involved with the fellow in the operating room and at VA medical center (Dr. Cohen). During the year the fellow will spend a total two weeks on other disciplines (Radiation Oncology, Medical Oncology, Endocrinology)

- a. Please use a block diagram to demonstrate how a fellow will spend an average week on head and neck surgical oncology.
- b. Please use a block diagram to show how a fellow will spend each year of fellowship.

These block diagrams should be attached to the application and clearly labeled.

Block Schedule for Fellow – First two Months: Head & Neck Endocrine

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Grand rounds, Academics, Tumor Board, OR half a day	OR	OR	Clinic	Case Conference Clinic	Rounds (two weekends of each month)	Rounds (two weekends of each month)

Block Schedule for Fellow – Last 10 months

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Grand rounds, Academics, Tumor Board	Clinic	OR	OR	Case conference OR	Rounds (two weekends of each month)	Rounds (two weekends of each month)

2. How will the fellow interact with the current surgical residency programs and other fellowship programs in terms of head and neck surgery?

The fellow has the primary responsibility for leading the residents while on service. Head and neck resident team is consisted of one intern (4 week rotation), one junior otolaryngology resident (3 months rotation), one fourth year general surgery resident (6 weeks rotation) and a fifth year otolaryngology chief resident (3 months rotation). The fellow will assign cases to resident based on their experience level and will assure that all the clinics are adequately staffed by residents.

3. What academic title will the fellow carry?

The fellow will be appointed as instructor in department of otolaryngology. The fellows are expected to obtain unrestricted license to practice medicine in state of Oregon. The fellow will be credentialed to evaluate and treat patient independently. However, adequate faculty supervision is assured at all times through tumor boards and weekly case

conferences. The faculty are involved in all surgical care and all cases are reviewed before any operative intervention. The fellow has the opportunity to schedule cases (in the latter half of fellowship) independently based on experience level and explicit approval of faculty members.

4. Outline the fellow's outpatient office or clinical responsibilities.
The schedule is designed in a way that fellow will see patients with faculty in the first quarter of fellowship. Later in the fellowship, if approved by faculty, the fellow will have his/her own clinic in addition to participating in faculty clinics. It is expected that fellow is able to manage less complex patients in the clinic. Faculty supervision is maintained at all times. The clinics in head and neck department are well equipped for minor procedures. The fellow is encouraged and required to master outpatient procedures such flexible endoscopy, biopsies, office ultrasounds, debridement...

5. Please attach the surgical experience reports for all of the resident physicians in this program completing their training during the past academic year.

F. FELLOWSHIP PERSONNEL INFORMATION

1. List head and neck surgeons and academic rank who will regularly work in the operation room with the fellow.

NAME:

RANK:

Peter Andersen, MD	Professor
Neil Gross, MD	Assistant professor
Mark Wax, MD	Professor
Paul Flint, MD	Professor
Joshua Schindler, MD	Assistant Professor
Maisie Shindo, MD	Professor
James Cohen, MD, PhD	Professor

2. List names and titles of all professional staff who will regularly participate in education of the fellow.

NAME:

TITLE:

David Sauer, MD	Assistant Professor of Pathology
John Holland, MD	Associate Professor of Radiation oncology
Andrew Palmer, PhD	Speech pathologist
Donna Graville, PhD	Speech pathologist
Teresa Kochanowski, NP	Head & Neck nurse practitioner
Jane Weissman, MD	Professor of Radiology
Bronwyn Hamilton, MD	Radiology
Gary Nesbit, MD	Neuroradiology
Stanley Barnwell, MD	Professor of Neuroradiology
Johnny Delashaw, MD	Professor of Neurosurgery
Paul Schipper, MD	Associate professor of Thoracic Surgery
Mithran Sukumar, MD	Associate professor of Thoracic Surgery

3. Provide curricula vitae and bibliographies of program director, assistant program director, and other individuals who are important to the program. Include complete CV of Program directors. All other CV's may be limited to two (2) pages.

If you have any questions regarding this application, please contact Aaron Goodman at:

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