Highlights from the Current Issue: June 2015

John H. Krouse, MD, PhD, MBA

I am pleased to present highlights from the June 2015 issue of Otolaryngology–Head and Neck Surgery. We have an interesting collection of articles in this issue that I hope you will enjoy exploring. In addition, we will also offer a series of papers that focus on the interface of variation, cost, and quality in health care, specifically looking at these factors in otolaryngology practice. With health care reform continuing to occupy a central role in medicine and public policy, it is a timely discussion for our readers.

Our first article this month examines public perception and awareness of the role of the human papilloma virus (HPV) as a cause of oropharyngeal cancer. In this paper, Williams and colleagues conducted a survey among civilians and military personnel that explored their knowledge of the relationship between HPV and oropharyngeal cancer.1 Results of this survey demonstrated that among 319 respondents, there was little knowledge of the association of HPV and head and neck cancer, while the majority of individuals were aware that HPV was a risk factor for the development of cervical cancer. Furthermore, the respondents were not aware of the potential role of the HPV vaccine for men and women in the prevention of oropharyngeal cancer. On the basis of their survey, Williams and colleagues stress the need for public education and advocacy in bringing awareness of this important association and the role for vaccination in HPV in preventing oropharyngeal cancer.

In a second paper, Vicente and colleagues evaluated the use of magnetic resonance imaging (MRI) in monitoring the activity of otospongiotic lesions among patients with otosclerosis.2 The authors utilized gadolinium-enhanced MRI scans to detect foci of active otospongiosis. They then followed 42 ears in 26 patients that were managed with 1 of 3 treatments—sodium alendronate, sodium fluoride, or placebo—demonstrating a statistically significant reduction in the size of otospongiotic lesions with active treatment. Vicente and colleagues also noted that MRI changes were more sensitive than clinical or audiometric evaluations in detecting reduction in foci of otospongiosis. The authors support the use of gadolinium-enhanced MRI in following the progress of areas of otospongiosis among patients with active otosclerosis.

In the third paper, Baik and Brietzke employed a Markov decision analysis to compare outcomes of 3 types of tympanostomy tubes: short-term grommet tubes, “intermediate”-type tubes, and “permanent” T-tubes.3 In this study, the authors prepared a cohort decision analysis model using a computer software program to assess these 3 types of tubes. Based on published data, the decision model featured complications such as perforation of the tympanic membrane, early extrusion or blockage, and the need for repeat tube placement after extrusion. From an analysis of cumulative utility, Baik and Brietzke demonstrated that the most optimal tympanostomy tube was the “intermediate”-type tube, in that it produced fewer perforations than T-tubes but allowed a longer period of ventilation than grommet tubes. The authors discuss the implications of their analysis in selection of appropriate tympanostomy tubes for children needing ventilation of the middle ear.

In the next paper, Rathi, Samuel, and Mehra examined patterns of nonresearch payments from industry to otolaryngologists and explored how conflicts of interest vary among otolaryngologists and other surgical specialists.4 Using the Open Payments database of the Centers for Medicare and Medicaid Services, Rathi and colleagues noted that about half of otolaryngologists were reported as receiving payments over the 5-month study period in late 2013, with a mean payment per compensated individual of $573. Of note, otolaryngologists received the lowest mean payment per compensated individual among all surgical specialists. While the authors do not examine all subspecialties in otolaryngology, since they are not tracked independently by the Centers for Medicare and Medicaid Services, and while differences may exist among unspecified practices, the current papers reveal that nonresearch payments from industry continue to be common among otolaryngologists. In summarizing their findings, Rathi and colleagues demonstrate that variation exists among otolaryngologists in their financial ties to industry and that the Open Payments database may serve as a future tool for self-regulation.

Finally, in an interesting and important paper, Cracchiolo and colleagues discuss variation in physician payment among academic otolaryngologists in different group practices in one American city.5 Using publically available Medicare Part B payment information based on Current Procedural Terminology coding from 2012, the authors examined 4 different practices and charges for patient visits and reimbursement received from Medicare. While all 4 practices were primarily affiliated with

1Department of Otolaryngology/Head and Neck Surgery, Temple University, Philadelphia, Pennsylvania, USA

Corresponding Author:
John H. Krouse, MD, PhD, MBA, Temple University, Otolaryngology/HNS, 3440 N Broad St, Kresge West #300, Philadelphia, PA 19140, USA.
Email: John.Krouse@tuhs.temple.edu
academic medical centers, there was a twofold difference in payment amounts among provider groups. In addition, the study demonstrated variation in how patient visits were billed, using evaluation/management codes, office-based endoscopic procedures, or a combination of the 2 approaches. These differences persisted despite adjustment for severity using hospital case-mix index. While not speculating on the reasons for disparate coding and reimbursement at various academic centers, Cracchiolo and colleagues do demonstrate significant variation in physician practices, even when patient severity is considered.

The Cracchiolo paper provides a current glimpse into variation in practice that has been present within otolaryngology for nearly a century. In an accompanying commentary, Sun describes the history of variation in otolaryngology practice dating back to the classic 1938 paper by Glover that noted disparate rates of tonsillectomy in adjoining districts in the United Kingdom. In addition, Gourin goes on to explore the important and sensitive question of whether the Cracchiolo data are an example of overuse of resources among individuals receiving higher levels of reimbursement. I further explore these issues in an editorial accompanying these papers.

I hope that you will enjoy reading these 5 highlighted papers, as well as the accompanying commentaries and editorial that you will find in this June 2015 issue. Health care policy and health economics are important to all otolaryngologists, and we will continue to focus on these important topics in future issues of the journal. I invite our readers to explore these papers and to feel free to provide feedback and commentary that will inform this important discussion. Enjoy your reading!

References