Dear Colleagues:

The Department of Otolaryngology-Head and Neck Surgery sends to you and your family our best wishes for a happy and healthy New Year.

We have been fortunate in the past year clinically and academically. Our clinical volumes continue to increase, and due to the loyal support of many of our referral private practice groups, many of whom trained at Loyola medical school or in our residency program, the tertiary and quaternary head and neck, skull base, and neuro-otologic cases continue to come our way.

We count all of our referral physicians as part of our Loyola family. Our aim is to provide prompt feedback on their patients, as well as a hearty thank you for the trust they place in us.

We too, would like feedback on how we are doing. Please call Ms. Jackie Burns at (708) 216-8526 to register any feedback you may have for us or to let us know if there are any problems in scheduling appointments for your patients.

We pledge to you our continued quality care for your patients. Again, I thank you for your support.

Sincerely,

James A. Stankiewicz, MD
Professor and Chair
Department of Otolaryngology-Head and Neck Surgery

Referring to Loyola is Easy

As a provider of tertiary and quaternary care, the professionals at Loyola University Health System (LUHS) are accustomed to sharing information about patients with the physicians who refer them. Keeping those lines of communication open and uncomplicated is important to both good patient care and healthy referral partnerships.

**Loyola Connect: An online referral portal**

To help streamline those communications, LUHS introduced Loyola Connect, an online portal for physician communication that reduces the need for phone calls and faxes between physician offices.

With Loyola Connect, referring physicians have access to the EHR generated by Loyola for each patient referred. By simply logging in to a secure account, referring physicians are able to review the very same information seen by Loyola specialists, including lab results, radiology scans, and physician notes.

When a new event is triggered, such as an admission or discharge, referring physicians receive email alerts, prompting them to log in to view the record. For security reasons, no patient information is included in the emails; it can only be accessed by logging into the system with the proper login ID and password. Physicians can always opt-out of email alerts if they desire.

Sign-up is easy. It can be done directly through the main LUHS website (www.loyolamedicine.org, click on “For Health Professionals” tab). Alternatively, you may contact Gisela Veltman Cuddihee, director of clinical information systems, for assistance. She can be reached at (708) 216-1333 or via email at gveltma@lumc.edu.

**Physician Referral Line: Referrals by phone**

At Loyola, we also have a dedicated telephone number to expedite physician referrals.

A registered triage nurse manages the line, Monday through Friday, from 8:30 a.m. to 5:00 p.m. The nurse records all of the pertinent information provided by the referring physician, and relays the details to the appropriate Loyola specialist. In most cases, an appointment is made available for your patient within seven days.

The Physician Referral Line is staffed 24/7. After regular hours, you can elect to leave a message (which will be returned the next business day), or request that the on-call specialist be paged if the patient's need is urgent.

To make a referral to Loyola, please call the Physician Referral Hotline at (708) 327-DOCS (708-327-3627).

**Additional improvements forthcoming**

Later this year, LUHS will implement Care Everywhere, a program that provides access to a patient’s medical records from other organizations, right at the point of care. This will give Loyola clinicians access to information that might be crucial to treatment of that patient, which might otherwise not have been accessible.

However you choose to communicate, know that Loyola is committed to keeping you informed about your patients’ care. Whether via our web portal or by phone, Loyola is always working to establish effective two-way communications, and maintain a positive experience for every referring physician.
Loyola ENT Ranked Among Nation's Best
The U.S. News & World Report 2013-2014 hospital rankings has rated the Department of Otolaryngology-Head and Neck Surgery at Loyola University Health System 33rd in the entire nation. Only three percent of all hospitals in the United States earn a national ranking in any specialty.

Grand Rounds: Evaluating the Patient With Facial Paralysis
By John P. Leonetti, MD

The facial nerve (cranial nerve VII) is responsible for all voluntary and involuntary movement of the muscles of facial expression. Paralysis of this nerve will result in functional deficits to eye closure, tearing, speech, and chewing. The psychological and emotional impact of a paralyzed face can be personally and socially devastating. Early identification of the cause of facial paralysis will lead to the optimal medical or surgical intervention.

Anatomy

Lower motor neuron lesions (which are the vast majority of facial paralyses) will result in complete weakness of the affected side of the face. The facial nerve crosses the cerebellopontine angle to enter the internal auditory canal (IAC) at the porus acousticus, along with the cochlear and vestibular divisions of cranial nerve VIII. The facial nerve makes a posterior turn (at the geniculate ganglion) and runs horizontally through the middle ear (tympanic segment). It makes another bend (or second genu) and runs vertically through the mastoid bone, exiting the temporal bone at the stylomastoid foramen.

The main trunk of the facial nerve enters the parotid gland and quickly separates into upper and lower divisions. These divisions split into five peripheral branches, each with several anastomotic branches innervating the muscles of facial expression. In addition to the motor function of the facial nerve, cranial nerve VII is also responsible for tearing, taste, salivary secretions, and cutaneous sensory innervation of the external ear canal.

Physical Examination

A complete head and neck examination must be performed in all cases of facial paralysis. Neck and parotid palpation may reveal lymph nodes or a parotid mass. The oral cavity should be assessed, along with an otoscopic view of both ears. The anterior nasal examination is usually normal, but nasopharyngoscopy might reveal a submucosal neoplasm of the infratemporal fossa. All cranial nerves should be clinically tested, especially Cr VIII (for hearing loss) and Cr V (for decreased corneal or facial sensation).

The facial nerve assessment must be accurately documented at the first clinical encounter: unilateral vs. bilateral; individual nerve branch(es) weakness vs. the entire hemi-face; and whether the nerve is partially weakened or totally paralyzed. The degree of facial weakness can be objectively recorded using the House-Brackmann grading scale.

Clinical History

The most important information in the history of a patient with facial paralysis is the time of onset. Acute facial paralysis (within 24-48 hours) is almost always due to Bell’s palsy. Conversely, delayed onset or partial facial weakness is never related to Bell’s palsy. The physician should ask about ipsilateral hearing loss, pain, prior surgery, skull fracture due to trauma, forceps delivery, congenital facial weakness, or a history of Lyme disease. Finally, especially in patients with peripheral branch weakness, a history of skin cancer may be important.

Diagnostic Testing

Acute onset facial paralysis due to Bell’s palsy requires no initial diagnostic testing. However, patients without functional recovery in 4-6 weeks should undergo an MRI of the internal auditory canal with contrast, to rule-out a neoplastic cause for the paralysis.

Patients with delayed onset facial weakness, peripheral branch weakness, or partial (incomplete) paresis must undergo radiographic assessment. MRI with contrast is used for patients suspected of having an intracranial or parotid neoplasm (Fig. 1). The use of MRI is based upon the suspected location of a possible tumor according to the presenting signs and symptoms. A CT of the temporal bones is used in patients with suspected lesions of the internal auditory canal. The middle ear, or the mastoid bone. An MRI of the IAC is done in patients suspected of having a posterior fossa tumor, while an MRI of the parotid gland is done in patients with a possible extratemporal neoplasm.

Audiometric testing will identify the type (conductive, sensorineural, or mixed) and degree of hearing loss, which will assist in selecting the radiologic modality of choice.

Electrodiagnostic testing, such as EMG or ENOG, may be used to determine the physiologic severity of the facial paralysis and the possibility of recovery. It may also be used to decide when to surgically decompress the facial nerve.

Differential Diagnosis

Bell’s palsy, the most common cause of facial paralysis, accounts for approximately 80% of unilateral facial weakness. Thought to be due to herpetic inflammation of the nerve, patients present with acute facial palsy (within 24-48 hours), along with ear pain or pressure, hyperacusis, and occasional imbalance. The facial paralysis may be self-limited, with full recovery in 1-2 months in up to 85% of the cases. In these cases, a three-week tapering course of steroids may shorten the recovery period by reducing the neural inflammation. Antiviral medications have not been shown to be effective.

Microsurgical decompression of the intratemporal facial nerve can be utilized in patients who show no clinical recovery after three months. A middle cranial fossa, or combined transmastoid approach, can be used to remove the bone from the facial nerve in the perigeniculate region (Fig. 2). The neural sheath is then opened to release the nerve from the peri neural encasement. Electrical stimulation using a monopolar stimulator can be used to “jump start” the facial nerve. Results over the past two years have shown faster recovery with less synkinesis when electrical stimulation is combined with bony decompression and early (1-3 month) postoperative retraining physical therapy.

Blunt trauma to the lateral skull may cause facial paralysis if a temporal bone fracture occurs. Delayed-onset weakness is usually self-limited and associated with a longitudinal fracture. Transverse fractures may cause immediate onset facial weakness, requiring surgical repair of a severed or crushed nerve.

Acute otitis media may cause facial paralysis in patients with involvement of a dehiscent tympanic segment of the facial nerve. Antibiotics with myringotomy and PE tube placement may be curative. Canal-wall-up mastoidectomy may be needed to decompress the inflamed tympanic segment of the nerve.

Chronic otitis media (with or without cholesteatoma) may also cause facial paralysis, due to granulation tissue invasion, or epithelial cyst compression of the nerve. Canal-wall-up or canal-wall-down mastoidectomy should be performed as soon as possible to prevent long-lasting facial weakness. Complete facial recovery can be expected if surgery is performed within 48 hours of the onset of paralysis.

Non-traumatic, gradual facial paralysis is most often due to neoplasms. The tumor may be intradural (meningioma, epidermoid, facial neuroma, acoustic neuroma, or hemangioma), intratemporal (glomus tumor, facial neuroma, carcinoma, or sarcoma), or extratemporal (benign or malignant parotid tumor, or skin cancer) (Fig. 3). The diagnosis can be made via history, physical examination, MRI, and/or CT. The surgical management is based upon the size and location of the lesion.
and location of the tumor. The facial nerve can be repaired primarily with an interposition graft by using a split hypoglossal to facial nerve anastomosis, or by utilizing a microvascular free tissue transfer (e.g., sternocleidomastoid or gracilis muscle). The neoplasm causing the facial paralysis may not be apparent on physical examination. Gradual-onset or partial facial weakness is not Bell's palsy; therefore a high-level of clinical suspicion must be utilized to diagnose a tumor in these patients.

A complete list of all causes of facial paralysis includes entities under the categories of birth-related, neurologic, infectious, metabolic, toxic, iatrogenic, and idiopathic, and is beyond the scope of this manuscript.

**Summary**

In up to 80% of patients with unilateral facial weakness that occurs over a 24-48 hour period, the cause is Bell's palsy. Use of observation only, or the use of oral steroids, results in excellent recovery in 85% of these patients. A neoplastic cause should be considered if the facial weakness lasts more than one month, and in all patients with gradual-onset facial weakness, incomplete paralysis, or peripheral branch involvement.

Surgical decompression of the facial nerve can be utilized if no recovery is seen in three months for patients with Bell's palsy or Ramsey-Hunt Syndrome. A variety of otologic, head and neck, and neurosurgical approaches can be utilized in patients with infectious or neoplastic causes for facial paralysis.

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**References:**


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**Loyola Breaks Ground on $137 Million Research and Education Center**

More than 300 scientists and dignitaries were present for the groundbreaking ceremony for the Loyola University Chicago Center for Translational Research and Education. The center will support nearly 500 scientists and staff in their work to improve human health.

The five-story, 227,000-square-foot building will include open laboratory and support space for 72 principal investigators, plus space for 40 lead scientists engaged in desktop research, such as public health, health services, nursing, bioinformatics, and epidemiology. A 250-seat auditorium will provide a unique link with the local community, serving primarily as a showcase for health-related programming.

The center, a collaboration between Loyola University Chicago, Loyola University Health System, and CHE-Trinity, will be located on the Health Sciences Campus in Maywood. It is scheduled to open in April 2016.

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**Spring CME Event Set for March 1**

A program designed to educate health care professionals on the causes and assessment of hearing loss, as well as a discussion of treatment options will be presented at Loyola on March 1, 2014.

Topics covered will include evaluation, middle-ear reconstruction, bone-anchored hearing aids, middle-ear implants, cochlear implants, vestibular schwannoma treatment, hearing aids and connectivity, and treatment options for tinnitus.

For more information, please contact Loyola’s Continuing Medical Education department Monday through Friday during regular business hours at (708) 216-3236 or 1 (800) 424-4850.

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**With Gratitude**

In order to continue providing residents with travel to academic meetings, books, loupes, and other necessities, Loyola’s ENT department created the Otolaryngology Resident Education Fund.

The following persons have donated to this fund, and we gratefully acknowledge these leadership gifts:

Sarah McDonald, MD

Resident education requires the efforts and support of many people. If you would like to help, please contact Dr. Stankiewicz directly at (708) 216-8526.

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**Kudos**

Congratulations to 2013 Loyola Otolaryngology-Head and Neck Surgery residency program graduates Eric Thorpe, MD and Ryan Burgette, MD.

Dr. Thorpe is now at the University of Cincinnati in a head and neck fellowship. Dr. Burgette has joined the practice at Midwest ENT Consultants in Naperville, Illinois.

Winners of the 23rd Annual Peter J. Girgis Resident Research Competition were announced in January. They include:

**First Place**
Jeffrey M. Hotaling, MD
A Pilot Study of Muscle-Nerve-Muscle Grafting for Facial Reanimation in Rats

**Second Place**
Nadieska Caballero, MD
Association Between Chronic Acetaminophen Exposure and Allergic Rhinitis in a Rat Model

**Third Place**
Lauren Murrill, MD
Differences in Distant Metastases for p16+/- Related OPSCC

**Fourth Place**
Sahar Nadimi, MD
Immediate Postoperative Imaging After Uncomplicated Endoscopic Approach to the Anterior Skull Base: Is It Really Necessary.

We extend our congratulations to the winners and the participants.
At the Podium

Laura Swibel Rosenthal, MD, was one of three presenters of “Older Siblings are at Increased Risk for Foreign Body Injury”, at the American Academy of Otolaryngology-Head and Neck Surgery annual meeting in Vancouver, B.C.

James A. Stankiewicz, MD was part of a panel called, “An Insightful Discussion” at the American Rhinological Society meeting at the American Academy of Otolaryngology-Head and Neck Surgery, also in Vancouver.

Later, at AAO-HNS, Dr. Stankiewicz was one of the presenters of a mini-seminar entitled, “Ask the Experts: An Endoscopic Potpourri”.

Carol Bier-Laning, MD offered an instructional course at the AAO-HNS annual meeting called, “PET Scans: The Who, When and Why and How to Get Reimbursed”. She was also a co-creator of a poster presented at the meeting entitled, “A Novel Use of Data Mining to Inform Outcome of Oropharyngeal Squamous Cell Carcinoma.”

Dr. Bier-Laning was invited to lecture at the American Speech-Language-Hearing Association Annual Meeting. She presented, “Transoral Robotic Surgery (TORS): How it has changed treatment of head and neck cancer”.

Amy Pittman, MD, presented, “AlloDerm with Split-Thickness Skin Graft for Coverage of the Forearm Free Flap Donor Site”, also at AAO-HNS.

John P. Leonetti, MD gave an oral presentation at AAO-HNS on “Facial Paralysis Following Gamma Knife Radiation of a CPA Neuroma” and developed a poster presentation on “The Influence of Body Mass Index and Other Patient Factors on Parotidectomy Complications”.

He was also the program director of the Facial Nerve study group at the American Neurotology Society Fall Meeting.

A group of Loyola physicians also presented a poster as part of 59th Annual Meeting of the American Rhinologic Society in Vancouver, BC:

Muhamad Amine, MD; Evan Greenbaum, MD; Michael Loochtan, MD; Richard Borrowdale, MD; William Ashley, MD; Kevin Welch, MD. Carotid Pseudoaneurysm from a Nasal Foreign Body Presenting as Epistaxis.

Meet the Docs

Dr. Patadia, a graduate of Northwestern University Feinberg School of Medicine, Chicago, Illinois, remained at Northwestern for her internship in general surgery, and residency in otolaryngology-head and neck surgery. She then completed an additional one-year fellowship in advanced rhinology, allergy and facial plastic surgery at the Midwest Sinus Center/Rush University, Chicago, Illinois.

She is certified by the American Board of Otolaryngology, and is a member of the American Academy of Otolaryngology-Head and Neck Surgery, and the American Rhinologic Society. Dr. Patadia was recently invited to help create national allergy statements for the American Academy of Otolaryngic Allergy, and is now on the board of the Chicago Laryngologic and Otologic Society.

Her special interests include revision sinus surgery, nasal and paranasal sinus disease, rhinoplasty, facial plastic surgery, cosmetic fillers, nasal allergy testing and immunotherapy, pituitary surgery, and general otolaryngology.

To make a referral to Dr. Patadia, please call the Physician Referral Hotline at (708) 327-DOCS or use Loyola Connect (found on the loyolamedicine.org home page)

Patients may make appointments by calling Central Appointment Scheduling at (708) 216-8563.

Feedback

We're always happy to receive your comments and suggestions Feedback

Visit our website: www.stritch.luc.edu/ent

unubscribe

Recognized as leaders in their field, the faculty of Loyola’s Department of Otolaryngology-Head & Neck Surgery are specialists in rhinology, otology, neurotology, skull base surgery, head and neck cancer, laryngology, voice and swallowing disorders, allergy, sleep disorders, general and pediatric otolaryngology. The department provides services in locations across the western and southwestern suburbs of Chicago, including Oakbrook Terrace, Woodridge, Wheaton, Home Glen and Burr Ridge, as well as at Gottlieb Memorial Hospital and the Loyola University Health System main campus in Maywood. For further information about the department or its services, please contact Jackie Burns, Office Manager at (708) 216-8526.