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    ii. **ACENTP request to Medicare for increased consulting fees for ENT Physicians (versus consulting fees for Surgeons).**

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1. PERTH – ASOHNS / ACENTP CONFERENCE 16/3/2013

By now you will know and we are happy to announce that we have been invited by ASOHNS to participate in their meeting in Perth in March. They have offered us the whole day of Saturday 16/3/2013 before their own meeting on Sunday. We are to run subjects of our own choice and these are proposed to be as follows **(see Programme below)**, though they may have to be altered as there is still a long time before finalisation.

We are grateful to our **Perth colleagues and members** who have been supporting us and taking an enormous amount of trouble (as taken by all, but especially the country and interstate members) in attending our Scientific Meetings. We really are proud of such members who do us a great honour and fuel our desire to represent their interests more as specifically involved with the Physician side of ENT, rather than the surgical side.

We do relate with ASOHNS on various issues and have a cordial relationship which is for the good of all. It enables our own medical expertise and experience to respond with any assistance they require and visa versa.

Again we value the support of our good colleagues from Perth who have earned our respect and gratitude, who obviously have played a role in, if not engendered the invitation to Perth and will endeavour to endorse their confidence in Perth in March.

AGENDA

Saturday 16 March 2013

8:30am - 4:45pm **Preliminary Program of the Australasian College of ENT Physicians Satellite Meeting**

8:55am
Welcome to delegates

9:00am - 9:30am
Dr Stan Stylis

ENT Physician's Role in Snoring and Obstructive Sleep Apnoea (OSA).
Dr Stylis is an ENT specialist who has an extensive experience in snoring and OSA. He will discuss his personal

observations and the principles of snoring and OSA, the physics of airway flow/obstruction, and ENT-specific endoscopic tests and their significance. Important indications for Palatal surgery will be discussed.

9:45am - 10:15am
Dr Brian Williams

Allergy of the Ears, Nose and Throat

Dr Williams is an ENT specialist and is an Associate Member of the American Academy of Otolaryngic Allergy. He will discuss allergic conditions of the ears, nose and throat.
Questions and Discussion

10:30am - 11:00am
Morning Tea

11:00am - 11:30am
Dr Joe Scoppa

Non-Allergic Rhinitis including Occupational Rhinitis.

Dr Scoppa is an ENT and has extensive experience in this area and will discuss non-allergic rhinitis including occupational rhinitis. Questions and Discussion.

11:45am - 12:15pm
Dr Brian Williams

ENT Physician Management of Chronic Sore Throat with a Negative Nasolaryngoscopy more than 25 Causes.

Dr Williams will discuss more than 25 Causes.
Questions and Discussion.

12:30pm - 1:15pm
Lunch

1:15pm -1:45pm
Dr Brian Williams

How to Bulletproof your Workers Compensation or Motor Accident Medico-legal Report.

Dr Williams will discuss how to write your report and give reasons for your opinion that are clear and unambiguous to the parties reading it.
Questions and Discussion.

2:00pm - 2:30pm
Dr Joe Scoppa

Assessment of Smell and Taste

Dr Scoppa will discuss the medical and medico-legal assessment of smell and taste.
Questions and Discussion.

2:45pm - 3:15pm
Afternoon Tea

3:15pm - 3:45pm
Dr Robin Hooper

"Acoustic Shock: Controversies".

Dr Hooper is from Melbourne and he will discuss acoustic shock controversies.
Questions and discussion.

4:00pm - 4:30pm
Professor Gunesh Rajan

"Tissue Engineered Repair of Tympanic Membrane Perforations: A local Anaesthetic Procedure".

Professor Rajan is from Fremantle and he will discuss the technique and results of a new method to repair tympanic membrane perforations.
Questions and Discussion.

4:45pm **Close of Meeting.**

2. The New Legislation for Workers Compensation Engineered by the NSW State Government

The three executives of the ACENTP who have expended much time and effort over the last six months including a number of executive meetings in considering very serious matters regarding Workers Compensation matters relating to changes to the law by the State government.

It began with our submission to the Parliamentary Committee enquiring into the NSW Compensation Scheme and dated 11/5/2011. We advised that the Committee should consult with various members of the Specialists involved in medico legal reports and that each body part or system should be considered by the appropriate college or Approved Medical Specialist for that particular discipline.

[No response other than acknowledgement of receipt was received and the subsequent decisions with respect to Industrial were illogical. However, neglecting our advice was used in subsequent correspondence to hammer home to the government that the changes were made in ignorance and led to erroneous conclusions.]

A 284 page Document listing the recommendations was issued by the committee which was read by the executive….. every word. This was received on the Thursday or Friday and a whole weekend was taken in examining the recommendations and a submission was put together and presented to the typist on Monday morning. This pointed to apparent errors and inconsistencies. Whilst she was typing the paper, the government was debating the bill! This put paid to the submission. The Workers Compensation Legislation Amendment Bill was produced in urgency which provided another tedious diversion. The changes with respect to Industrial Deafness were draconian. All NSW Members will probably be aware that the **threshold had need to be breached before a claim for lump sum compensation could be made, was raised from 6% BHI to 20.5% BHI (WPI 11%) which would eliminate some 80 to 90% of the claims for industrial deafness.**

Then both individually and in concert, the executives sent letters to the Premier, Barry O'Farrell, and to the Minister for Finance and Services, Greg Pearce MLC. These letters pulled no punches. Other people of influence were notified.

In our correspondence we emphasised to the Premier and Minister that the Parliamentary Committee had confused BHI with WPI and thus their whole deliberations were based on erroneous information. They then understood the value of our initial advice and directed the WorkCover Authority to seek a meeting with us which was duly held.

Thus the Executives of ACENTP were invited to meet with the WorkCover Authority to assist in formulating Impairment Tables and advising on other aspects of the Workers Compensation guidelines for Industrial Deafness. However we could not cover the myriad of issues in two or so hours. We pointed out that the problem was also that the old guidelines were not compatible to the new law, so that no one was sure how to handle the compensation cases for industrial deafness. Consequent confusion led to the dismissal of many solicitors from their large law firms and caused the smaller firms much financial stress, not to mention ENT Specialists with a significant medico legal practice. In fact it has affected all parties in the medico legal industry.

It is inappropriate for us to publish letters and details discussed; it suffices that the WorkCover Officers listened attentively to our analysis and promised to have our concerns carefully considered. At this stage we have no idea as to the acceptability of our recommendations or how long it will take to incorporate them.

The executive was determined to alter the regulations with respect to industrial deafness and separate them from the other body parts and systems as they were of an entirely different nature of injury. Industrial deafness is a chronic and ongoing injury whereas the other injuries in general are acute injuries (except for a small number of conditions). A large number of suggestions were mooted.

Delayed Messages **(written October 2012)**

It is not possible to go into great detail on the continuing and ever changing efforts that the executives of ACENTP have put on your behalf. The amount of work involved in correspondence and meeting the various authorities such as the Premier of NSW and the Minister involved, the WorkCover Authority and the contacts with the Federal Government and recently, with the Labor Council in NSW that control 68 unions and 800,000 workers, with respect to the Workers Compensation Law and all the parties involved in the compensation process, has made it impossible for us to plan an earlier meeting or to publish numerous items of news and papers in the eJournal.

However we believe this has resulted in much benefit in the final deliberation of the authorities with respect to the effect on the medico legal reporting.

Discussions were carried out with various lawyers, with contacts in the Labor Council, with media personalities and also with contacts with the Federal Opposition party and put forth our main concerns. Meetings of the College took place with such parties and further meetings with the minister are planned.

1. Perhaps the key matters include one of the disastrous effects of the determination of the threshold and how it has virtually denied access to 90% of the workers subject to industrial deafness.

2. The decision to allow only one set of hearing aids to be issued with no clear indication of what is to happened down the road when these hearing aids are not functioning properly.

3. The complex situation with respect to who will pay the legal and medical fees. It is mooted that the worker themselves is responsible for the costs though the exact considerations have not yet been announced.

4. The means of calculating the quantum of impairment.

5. The issue of deterioration of the hearing during further employment over a number of years.

6. How to decide an old injury from a new injury as far as industrial deafness is concerned, any consideration given to this.

7. What protocol to follow during this prolonged period from the start of the law on the 19/6/2012 until all these details are resolved. This has resulted in great confusion, loss of employment for lawyers, sudden interruption of the medico legal segment of the specialist practice and so on.

Further confusion led to argumentative workers who demand some compensation despite the matters being out of our hands and causing us embarrassment at the apparent confusion which has been imposed upon us by the legislators.

I leave this brief précis for you, but our work is continuing in this respect. We hope we may be able to ameliorate the threshold of tables and reduce them from the level of 20.5% BHI at which they stand now. But the government won't budge.
They had announced that they were attempting to follow the Victorian model, but in fact, either by error or design, they failed to take into account that in Victoria, a 10% WPI is equivalent to approximately 10% BHI. By making 11% WPI the threshold level in NSW meant that this was equivalent to a 20.4% BHI. This is an increase of the threshold from 6% BHI to 20.4% BHI which seems excessive and illogical.

It has been pointed out that 20% injury to one's elbow is less restrictive than 20% injury to one's hearing. At least with 20% injury to one's elbow can still enjoy holding his beer in his other hand whilst enjoying conversation with his mates at the pub. Whereas a hearing loss is with you twenty four hours a day causing problems listening to the television and other social activities. Causing friction in the household, squabbles and arguments and causing isolation of the worker and reduction of his job prospects. Furthermore, hearing affects both ears whereas other injuries are determined on a single injury, if there is an injury in another part or the opposite part, then these can be added together.

We are working through a whole host of similar considerations and I assure you it has taken an enormous amount of our time.

We bring you this news so that you are aware that we have our finger on the pulse of what is going on matters that may affect our members and that we are prepared to act to protect the rights and the interests of our members.

January 2013

It has now been 7 months since the NSW Government ambushed the workers compensation process. Since then, we have continued our discussions and questioning the various authorities. We are sure that our constant contact and efforts have ameliorated the thinking of the authorities as we have indicated that we would not lay down but would continue our efforts in any way we could.

Some disclosures are emanating from the WorkCover Authority and clarification of the prescription for hearing aids has been announced. Still there is a fair amount of confusion existing in providing clear guidelines.

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3. DIAGNOSIS & TREATMENT – A Doctor's exclusive domain

We have been involved together with ASOHNS in various submissions to the Federal Government and Medicare. The College strongly upheld the position of Doctors in maintaining their standards in a clear and definite fashion. The key principle is that there is no other professional who is qualified to make a clinical diagnosis other than a Medical Practitioner.

There is a constant barrage from paramedical people and others trying to secure some acknowledgement in the question of diagnosis. Everybody wants to be a Doctor, the nurses want to be a Doctor, our staff want to be Doctors, the wives want to be Doctors, the lawyers want to be Doctors, patients looking up the internet think they are Doctors, even insurance claims officers think they are Doctors.

No diagnosis can be made on a one single parameter. What must be emphasised, by all members at appropriate occasions, is that the most important part in formulating a diagnosis is the medical history and the physical medical examination; and at specialist level by a medical practitioner specialist in the field. The various technical investigations are necessarily considered only in conjunction with the clinical findings. There must be a deep understanding of anatomy, physiology, differential diagnosis of disease states and congenital and developmental matters; and such numbers of sciences being cemented by practical experience.

Nothing shorter than this.

We can respect the skilled technicians but must always keep the principle of diagnosis and treatment in check, else we will be overwhelmed by the current corrupting attitude of society and authority in debasing and degrading hard earned professional scholarship and wisdom, built on many years of study, research and learning.

Such position cannot be claimed by paramedicals who are doing clinical tests which then have to be considered and possibly acted upon by the Medical Practitioner. The tests are considered in making a diagnosis but are not a diagnosis themselves. The paramedical who thinks they are making a diagnosis do not take responsibility for any management. We have made these views clear and expect you both as registered Medical Practitioners and trained Specialists to strongly defend these principles.

Stan Stylis **Editor**

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4. JOINT PROPOSALS by ASOHNS and ACENTP

We are very happy with our deepening association with our head ENT association ASOHNS. We have cooperated in many parts of the above issues and the following:-

i) A request from Medicare with comments regarding Audiologists.

You may have read the message from ASOHNS mentioning our involvement with them in forwarding information to Medicare with respect to Audiologist rebate and entitlement. Medicare requested a significant amount of information so as to understand where audiology fits into our speciality in the general medical scene. I assure you that deep and serious communications follow cooperating with ASOHNS but, as it was more specific to ACENTP and especially in medico legal work, ACENTP spend time at a much detailed consideration. Such details cannot be published on our website as currently our section is not restricted to our members and is not yet complete. (member section being finalised now).

ii) Application to Medicare for increased Consulting fees.

ACENTP has applied to Medicare for consideration of increased fees for consultations by members of ACENTP, that is non surgical Ear Nose and Throat Specialists. In contrast to fees and consultation available for surgeons. This is based on the fact that surgeons make their income mainly from surgery and the consultation fees are kept to a minimum whereas an Ear Nose and Throat Physician spends a lot of time consulting, in investigation, in follow up and more, and does not receive income from surgery.

Editor

ABSTRACTS / PAPERS

1. ASPECTS OF TINNITUS DISCUSSIONS

CONCLUDING PRESENTATION Stan Stylis FRCS

3rd ACENTP Scientific Meeting FEB 2012

A. Considering the patient presenting with Tinnitus

B. ODDS & ENDS

- **i) How does noise therapy work ??**
- **ii) The medico legal significance of tinnitus**
- **iii) How can tinnitus occur from a problem in the jaw or jaw joint**?
- **iv) How can tinnitus occur from a problem in the jaw or jaw joint**?

Consideration of patient with Tinnitus

This suggested broad plan in considering people presenting with tinnitus is assuming a full history is taken and other serious pathology excluded; it is to be kept in mind that the presence of any other pathology does not mean that it is this disorder that is causing the tinnitus. ***TMJ problems are common and can be causing the tinnitus even if there is obvious or potential ear or other pathology present***.

1. Examine the TMJ in all patients presenting with ear nose or throat symptoms. It is surprising the vast number of symptoms that can arise from the jaw joint. It was shown that at least half of the patients that have TMJ dysfunction have tinnitus as one of the symptoms and in these patients treatment of the TMJ results in a success rate eliminating these sounds in sixty to ninety percent of the cases as reported in the literature. A two year survey suggests that the improvement is sustained over time.

It only takes sixty seconds to get a pretty good idea of the bite and the temporomandibular joint details I have discussed in my article published in ACENTP eJournal Vol.1.(www.acentp.org)

2. Not only do we notice missing teeth, crossbites, overbite and so on but the temporomandibular joints should be palpated just by placing a hand on each side of the jaw joint after the patient opens and closes their mouth and noting the extent of the movement and how far up the jaw joints poke out laterally and whether there is any crepitus or tenderness. Also observe how the mouth opens and whether it deviates from one side to the other or has a zig zag movement.

3. Ask the patient to test the theory over the next four weeks (if they have sufficient teeth) by avoiding hard food. Explaining that day to day meals are not hard and only certain items are hard such as crusty bread in particular, nuts and anything that is very chewy. The advice is not so much as to eat soft food but to **avoid hard or chewy food** for a period of 4 weeks.

4. If the tinnitus has made a significant improvement then they have proven to themselves that there is a relationship with the TMJ. If the tinnitus is reduced to their satisfaction then they may choose to stay off hard food or avoid opening their mouth too wide.

   If the tinnitus does not improve then they should be referred to a Prosthodontist for consideration of treatment to their dental malocclusion.

5. If there is no joy along these lines, then the ENT Specialist should consider the other options as they themselves favour. You may choose to treat the patient yourself or refer them onto a colleague who has a special interest in treating tinnitus. The choice depends on your own personality and experience and your understanding the patient, their problems, their attitudes and emotions and their finances.

6. You may decide on the tinnitus retraining therapy (TRT) which includes many investigations and encouraging the patient with an explanation to their problem including the use of sound generators or combination sound generators/hearing aids. Perhaps some medications.... such as Rivotril which has an effect on the reducing transmission of impulses along nerves. You may finally decide if some other noise therapy is indicated such as Tipa or others.

7. You have the option of directing and advising the worker in a very positive way.

ODDS AND ENDS

How does noise therapy work ??

I believe the answer may be very simple. ..... When you first wear a pair of spectacles you keep seeing the rims, but after a few days or a week or so, the brain gets "accustomed" to seeing the rims and you rarely notice it anymore. I believe that this adaptation is what happens when recurring or constant noises are applied to the ear and, after a while the brain doesn't bother about it anymore and it is suppressed into the background just like the rims of your spectacles.

What is more important is that the patient accepts this explanation and the reassurance and understanding is plausible and goes a long way in assisting his tolerance. It doesn't matter what the cause of the tinnitus is otherwise. The brain adapts with the presence of tinnitus.

All the discussions and theories of neural circuits involved merely explain how this adaptation process is accomplished.

The medico legal significance of tinnitus.

I take a cautious view towards complaints of tinnitus. If these people have definite dental malocclusion or temporomandibular joint dysfunction, it is much more likely that the problem is primarily, or in the main, coming from the TMJ than from any cochlear trauma. The worker should be told that if they still have bad tinnitus two or three months after the use of hearing aids, then they are welcome to return for consideration of further management. Everytime I have offered this, no one has ever come back. This may mean the tinnitus was exaggerated or the explanation has been accepted by the worker and they don't worry about the tinnitus anymore, or, having derived some benefit from the hearing aids or being happy at receiving their compensation they no longer have to focus on their tinnitus.

That some tinnitus can occur with hearing loss/damage is not denied and the examination of the bite and TMJ and the degree of abnormality can be considered against the nature of the noise to which a worker has been subjected and the conformation of the audiogram eg a sharp drop in the high frequencies. In marked hearing loss tinnitus is much less likely to be present.

How can tinnitus occur from a problem in the jaw or jaw joint?

Every joint has a nerve supply that senses pain. Usually that nerve supply also serves the muscles to move that joint. When the joint is injured, the muscles go to spasm to fix the joint to facilitate it's resolution by restricting movement.

If you are struck on the patella ... your thigh becomes stiff. It wasn't your thigh that was struck. If the damage is more extensive, the reflex spreads and your hip becomes stiff. Using that sort of simile, the temporomandibular joint is supplied by the fifth cranial nerve and this sends a branch to the tensor tympani. So that when this goes into spasm it tenses the eardrum and stiffens up the ossicular chain, it reduces the transmission of sound. The worker often complains about it being a deafness but indeed it's more accurately described "as a sensation of blockage in the ear". Other symptoms like "something moving in the ear" or "water running in the ear". As the stiffening of the ossicles tend to pull on the oval window, altering the pressure relationships in the cochlea giving rise to tinnitus.

Again this explanation is something that the patient can understand and they feel more comfortable at having the explanation.

! **Tinnitus after Injuries**

It has been reported in the literature that between 85 and 90% of whiplash injuries in the neck are associated with tinnitus. This is thought to occur due to concurrent "jawlash" accompanying the whiplash of the neck.

In the rough and tumble of a motor vehicle accident, yes the neck gets swung around but also the head and jaw can hit up against the windscreen or window resulting in a direct injury to the TMJ and mandible. If there is a pre-existing vulnerability because of dental malocclusion, the injury need not be excessive to trigger off symptoms.

Similarly in head injuries from falling over at work and hitting their head, a concomitant injury to the side of the head or on their jaw or chin or a smack across the face can also give rise to injury to the jaw. Losing a tooth or more is further evidence of substantial injury and leads to dental malocclusion with its own continuing cause of TMJ dysfunction.

This again emphasises the importance of examining the TMJ in all people reporting with ENT symptoms.

Stan Stylis FRCS

POWER POINT PRESENTATIONS **by Dr. Malcolm Baxter FRACS**
Melbourne

i) **Care of the Professional Voice** **ACENTP 2012**

ii) **The Otolaryngologic Uses of Botox** **ACENTP 2012**

CLICK ON FOLLOWING LINK TO START POWERPOINT PRESENTATION