

Argomenti di Otorinolaringoiatria Moderna

*Organo ufficiale della Associazione Italiana
Otorinolaringoiatri Libero-Professionisti
A.I.O.L.P.*



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ABSTRACT BOOK
of
First Bulgarian - Italian Rhinology
Friendship Meeting - Plovdiv, Bulgaria
17th - 19th May 2012



2012

Presentazione

È con piacere ed affetto che ho accolto l'offerta della Prof.^{ssa} Dilyana Vicheva, otorinolaringoiatra presso l'Università di Plovdiv (Bulgaria), di pubblicare gli Atti del Primo Convegno Bulgaro - Italiano di Rinologia svoltosi nel maggio 2012 a Plovdiv.

Ma con rammarico la Redazione è stata obbligata a modificare gli scritti originali, togliendo il testo in lingua bulgara ed italiana, che affiancavano gli articoli, lasciando così solo il testo in inglese.

Nella speranza che comunque il testo in inglese, lingua ormai abituale nella cultura medica, non porti svantaggio a nessuno, auguro a tutti i nostri lettori di aprire questa nuova frontiera con un oriente a noi poco conosciuto, ma che rivela preparazione, efficacia e serietà professionale.

Il Direttore

Introduction

I have accepted, with pleasure and affection, the offer of M.D. Dilyana Vicheva, ENT doctor Plovdiv Medical University (Bulgaria) to publish the Abstracts of the First Bulgarian-Italian Rhinology Friendship Meeting, occurred in may 2012, in Plovdiv.

To my regret, the editorial team had to adapt the original text of articles and in that process the Bulgarian and Italian translation had to be removed so that only the English version could be printed. I do feel, however that the English language, nowadays so frequently used in medicine, would safely be understood by all our Readers. I wish for all of you to go beyond this Eastern new frontier, really unknown to many people, and deeply appreciate their skill, talent and cleverness in the work.

Editor

Future perspectives of the bulgarian FIRST BULGARIAN - ITALIAN RHINOLOGY FRIENDSHIP MEETING

Dilyana Vicheva

*Department of Otorhinolaryngology,
Medical University, Plovdiv, Bulgaria*

The Bulgarian Rhinologic Society has had a long standing tradition of producing leaders in Bulgarian otorhinolaryngology. Originally started in 2004 under the leadership of Ognyan Despotov. Every year the Bulgarian Rhinologic Society provides the highest level of dedicated rhinologic subspecialty training programmes, courses and education of the residents.

In Europe we will have to collaborate more intensively with the other rhinologic societies. The Bulgarian Rhinologic Society has a wonderful collaboration with the Italian rhinologists. The First Bulgarian-Italian Rhinology Friendship Meeting will start with our future rhinology activities including exchange programmes for residents and specialists, clinical and research experience, rhinology research laboratory experiments etc.

The future of rhinology is in the international friendships, fellowships and grant programmes. Bulgaria and Italy will be among the leaders in the European Rhinologic Society and in the International Rhinologic Societies.

БЪДЕЩИ ПЕРСПЕКТИВИ ПРЕД БЪЛГАРО-ИТАЛИАНСКОТО РИНОЛОГИЧНО ПРИЯТЕЛСТВО

Диляна Вичева

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Българското Ринологично Сдружение има дълга традиция на изгражда лидери в Българската оториноларингология. То се сформира през 2004 г. под ръководството на Проф. Д-р Огнян Деспотов. Всяка година Българското Ринологично Сдружение провежда на най-високо ниво ринологични специализирани обучителни програми, курсове и обучение на специализанти.

В Европа ние ще трябва да си сътрудничам по-интензивно с други ринологични асоциации. От дълго време, Българското Ринологично Сдружение има едно прекрасно сътрудничество с италианските изявени ринолози. Първа Българо-Италианската Ринологична приятелска среща ще започне с нашите общи бъдещи ринологични дейности, включително програми за обмен на специализанти и специалисти, клинични и изследователски проучвания, ринологични лабораторни експерименти и др.

Бъдещето на Ринологията е в международните приятелства, стипендии и програми за отпускане на безвъзмездни средства за обучение и практика. България и Италия ще бъде сред лидерите в Европейската Ринологична Асоциация и в Международните Ринологични Общества

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FUNCTIONAL RHINOSEPTOPLASTY & REVISION RHINOPLASTY

I. Tasca, G. Ceroni Compadretti

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Rhinoplasty is a surgical procedure that modifies the external aspect and the functional characteristics of the nose through manipulation of the skin, cartilage, and underlying bone. The techniques of modern rhinoplasty are based on the concept of preserving and reorienting tissues as an alternative to surgery, which involves the sacrifice of large segments of cartilage and bone, thus creating unnecessary tissue voids that recover and scar in an unpredictable way. Therefore, conservative surgery increases the surgeon's control over the outcome, since it facilitates an appropriate balance between the corrected support structures and the tissue coating. The concept of function in rhinoplasty derives from the recognition, and, therefore, the preservation of some generic and specific anatomical segments. The purpose of this presentation is to describe these segments and underline their importance with regards to nasal function.

Secondary rhinoplasty is a consequence of inadequate or incorrectly performed primary surgery and it is one of the most challenging

plastic surgery procedures. Even expert surgeons report an average revision rate varying from 8% to 15%. Revision rhinoplasty can range from minor correction to complex reconstructive procedures and for this reason rhinologist must consider both aesthetic and functional principles and the skilled use of different surgical weapons. In fact, this surgery requires extensive knowledge of different techniques which must be modified according to the specific defects. Preoperatively, clear and detailed analysis of the deformities is essential for choosing the most appropriate operation and for the planning of the different surgical steps. Preoperative photographic documentation of the deformities should be taken carefully and, in this view, informed consent should take into consideration all the potential variables which can influence the surgical outcome. In this presentation, the Authors will show their experience in secondary rhinoplasty, underlying some anatomic and functional key-points which have to be respected in order to lower the causes for revision surgery.

IMPAIRED NASAL BREATHING AFTER RHINOPLASTY

Rumen Benchev

President of the Bulgarian Otorhinolaryngologic Society, Head and Neck Surgery

Thirty four patients with post rhinoplasty nasal obstruction were examined. Clinical and functional methods for assessment of nasal breathing were applied. Decrease of minimal cross sectional areas and nasal volumes and increase of nasal resistance were found.

The evaluation of nasal obstruction with visual analog scale showed 23.5% with severe nasal obstruction and 50% with moderate obstruction. The following pathological changes

were found: 18 cases with deviated nasal septum; collapsed and deformed upper lateral cartilages in 15 cases; collapsed alar cartilages in 13 cases; narrowing of the pyriform aperture in 4 cases; scars and adhesions in 11 cases and hypertrophy of the inferior turbinate in 6 cases.

Based on the performed observations, recommendations for functional rhinoplasty and revision surgery are made.

HMGB₁ - A NOVEL MEDIATOR OF NASAL INFLAMMATION

L. Cavone

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High mobility group box 1 (HMGB₁), an ubiquitous protein present in the nuclei and cytoplasm of almost all cell types, emerged as key mediator of inflammation during sterile and infection-associated responses. When released by activated immune cells, HMGB₁, acts as a pro inflammatory cytokine able to establish a vicious cycle of inflammation, promoting the recruitment, survival and activation of many different immune-cell types. Increasing evidence underlining the importance of HMGB₁ in many different inflammatory conditions suggest an important role

for the protein in ENT pathologies too. Many different strategies have been proposed to prevent the release or to block the action of HMGB₁ in order to reduce inflammation but, unfortunately, none succeeded in the clinical arena. Recently glycyrrhizin, a natural compound obtained from licorice root, demonstrated its ability to block the pro-inflammatory effects of HMGB₁. On this basis we investigated the effects of a potent glycyrrhizin derivate, 18-glycyrrhetic acid, on HMGB₁-induced inflammation in different cells playing a pivotal role in ENT pathologies.

TRANSNASAL ENDOSCOPIC CONTROL OF EPISTAXIS

Nicolas Busaba

Department of Otology and Laryngology, Harvard Medical School and Department of Otolaryngology, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts, USA

Introduction: Epistaxis is a common clinical disorder. Treatment is dictated by its frequency, severity, and location. The majority of anterior epistaxis cases can be controlled with conservative measures. Posterior epistaxis is typically more severe and harder to control. The traditional modes for controlling posterior epistaxis include various forms of packing, arterial embolization, and surgery. Transantral internal maxillary and ethmoid artery ligation can be associated with significant morbidity.

Objective: Describe our experience with endoscopic transnasal control of epistaxis.

Material and Methods: This is a retrospective review of 35 consecutive patients who presented with posterior epistaxis and failed nasal packing. Clinical data reviewed included patient demographics, sinus CT imaging, nasal endoscopy findings, surgical technique, operative complications, and length of hospital stay.

Results: The study group consisted of 24 males and 11 females with a median age of 57

years. CT and CT angiogram aided in surgical planning. The source of bleeding was superior nasal septum in 12 patients, posterior nasal septum in 6 patients, and lateral nasal wall in 17 patients. Hemostasis was achieved by endoscopic cauterization in 22 patients and sphenopalatine artery (SPA) ligation in the remaining 13 patients. Average surgical time was 50 minutes, average blood loss was 50 ml, and average hospital stay was one day. There were no operative complications. The surgical technique of SPA ligation will be described with a video demonstration.

Conclusion: Transnasal endoscopic control of epistaxis is effective in the treatment of posterior epistaxis. The surgery allows for an accurate diagnosis of the source of bleeding and targeted hemostasis. In addition, it has low morbidity, short operative time, and short hospital stay. The majority of cases does not require formal SPA ligation, and hence may be staffed by any otolaryngologist familiar with endoscopic techniques.

GLICERRETIC ACID NASAL SPRAY IN RHINOSINUSAL PATHOLOGIES IN ADULTS: RATIONALE AND RESULT

V. Damiani, C. Viti, M. Simone, A. Camaioni

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Introduction: Emerging and increasing evidences showed that HMGB1 (High Mobility Group Box1) protein can be considered as an extremely potent flogistic mediator able to activates specific membrane receptors such as TLR-2, -4, -9 and RAGE on a large number of cells including eosinophils, macrophages, granulocytes, dendritic cells, fibroblasts and endothelial cells, with release of various cytokines, chemokines, prostanoids and HMGB1 itself. Specifically, extracellular HMGB1 is strongly involved in the formation and maintenance of vicious inflammatory cycles that lead to the development of acute and chronic rhinosinusal pathologies.

High levels of HMGB1 had been already demonstrated in nasal secretions of patients affected by rhinosinusitis, allergic rhinitis, turbinate hypertrophy and nasal polyps. Glicerretic acid, an HMGB1 scavenger, resulted able, in "in vitro" studies, to inhibit extracellular flogistic activities of HMGB1.

A recently developed medical device, based on the topical use of dipotassium glicirizinate and mannitol opens interesting prospects in the treatment of rhinosinusal pathologies.

Aim of the study: To evaluate efficacy and tolerability of dipotassium glicirizinate and mannitol nasal spray in acute and chronic inflammatory rhinosinusal pathologies.

Material and methods: 34 patients with acute inflammatory rhinosinusal pathologies and 56 patients with chronic inflammatory rhinosinusal were enrolled. Rhinosinusal specific signs and symptoms on a 0-3 severity scale and nasal obstruction on a 0-

10 VAS were evaluated before and after treatment in all patients. Turbinate hypertrophy and nasal polyps dimensions (chronic group) pre- and post-therapy were also analyzed. Treatment consisted in 2 puffs/nostril of spray administered 2 times/day for 7 days in the acute setting and for 30 days in patients with chronic diseases.

Results: Nasal congestion, rhinorrhea, post-nasal drip and headache significantly improved after therapy ($p < 0.001$) both in patients with acute and chronic rhinosinusal pathologies. VAS for nasal obstruction decreased, in the acute patients group, from a pre-treatment mean value of 7,6 0,71 to 2,9 1,30 after therapy ($p < 0.001$) and in the chronic group from 7,4 0,45 to 3,0 1,10 ($p < 0.001$). Turbinate hypertrophy significantly decreased in both acute and chronic patients ($p < 0.001$). 12 patients with chronic rhinosinusitis had nasal polyps; specifically 8 patients had grade III polyps and 4 patients had a grade II polyps before treatment. After 1 month of spray, 9 patients had grade I polyps, 4 had grade II, and 1 had grade III polyps ($p < 0.001$).

No serious adverse effects were recorded. Concerning spray palatability, 28/34 acute patients and 38/56 chronic ones judged it as good, 4/34 acute patients and 14/56 chronic patients considered it as acceptable and only 1/34 and 3/56 defined it as not acceptable.

Conclusions: Further studies are needed to confirm these preliminary data, but a new interesting topical treatment for both acute and chronic inflammatory rhinosinusal pathologies had certainly been found.

ALLERGIC RHINITIS IN CHILDREN: PRELIMINARY RESULTS AFTER CORTICOSTEROIDS OR GLYCYRRHETIC ACID NASAL TREATMENT

C. Cuppari, S. Manti, M. Sturiale, I. Loddo, L. Grasso, C. Salpietro

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Glycyrrhizin (GL), a major component of licorice, could be considered as a new effective drug candidate to treatment of allergy, based on its anti-inflammatory activity. This study aimed at verifying whether GL nasal treatment could change nasal mucus levels of high mobility group box 1 (HMGB1) in children with allergic rhinitis. The HMGB1 is secreted by activated cells of the innate immune system and/or released by injured tissues and necrotic cells; HMGB1 up-regulates proinflammatory cytokines in several inflammatory diseases. Globally, 35 children (19 3.7 years), with allergic rhinitis ± males and 16 females, median age 9.3 and monosensitized to parietaria, were evaluated. The control group consisted of 24 healthy children (11 males and 13 females, median age 4.1 years). Allergic children were randomly assigned to receive, ± 9.1 for seven days, nasal GL treatment (n=12), nasal corticosteroids treatment (n=12) or placebo (n=11).

Nasal mucus HMGB₁ levels were measured at baseline (T₀), after seven days (T₁) of treatment.

At baseline, HMGB1 levels in nasal mucus were higher in children with allergic rhinitis than in control group (96.9±19.3 ng/ml vs 9.27±4.01 ng/ml; p<0.001). At T₁, HMGB1 levels in nasal mucus were significantly diminished (p<0.001) in children treated with nasal GL and CS (23.5±6.3 ng/ml and 28.14±7.2 ng/ml respectively) compared to the placebo group (72.6±12.7 ng/ml). Moreover, the symptom scores were significantly decreased (p<0.001) in children treated compared to the placebo group, whereas no significant difference was observed between the two treatment groups. The present study provides evidence that: 1) nasal mucus HMGB₁ levels could be a suitable markers of inflammation in allergic rhinitis; 2) GL nasal treatment could have glucocorticoid-like anti-inflammatory effects.

GLICERRETIC ACID NASAL SPRAY IN RHINOSINUSAL PATHOLOGIES IN ADULTS: PRELIMINARY EXPERIENCES IN BULGARIA

Dilyana Vicheva

Department of torhinolaryngology, Medical University, Plovdiv, Bulgaria

The diagnosis of rhinitis and rhinosinusal pathologies in clinical practice is based on the patient's history and symptoms, and the clinical findings. We investigated 32 patients. There were 19 women and 13 men, the average age was 37.6 years (range: 18-59) in the by means of acoustic rhinometry in the Department of Otorhinolaryngology of Medical University, Plovdiv, Bulgaria. All of them had history and clinical symptoms for different rhinitis and rhinosinuitis. Their basic complaint was nasal obstruction. In order to evaluate objectively the reaction of their nasal mucosa we used acoustic rhinometry.

The investigation was performed on the first

and 6 days after treatment with glicerretic acid nasal spray. We analyzed the results of the cross sectional areas (MCA) up to 8 centimeters from the tip of the nose. During the first visit we registered nasal obstruction in the region of the nasal valve (MCA=2.58 cm²). Six days after treatment with glicerretic acid nasal spray the average value of the MCA was 2.82 cm².

It is concluded that intranasal glicerretic acid nasal spray is quite effective with minor side effects and could be used successfully as a first line treatment in different rhinosinusal pathologies in adults. Acoustic rhinometry as an accurate objective method for measuring of intranasal geometry is a reliable means for monitoring of the treatment results.

TREATMENT OF HABITUAL SNORING AND MILD FORMS OF SLEEP APNOE BY PALATOPLASTY USING CARTILAGE IMPLANTS FROM THE NASAL SEPTUM

Rumen Benchev, Svetla Vasileva

President of the Bulgarian Otorhinolaryngologic Society, Head and Neck Surgery

The goal of the report is to share our results in the treatment of habitual snoring and mild forms of sleep apnea by implanting cartilages from the nasal septum in the soft palate.

The following methodology was used: in cases with nasal obstruction due to septal deviation and snoring, the cartilages left after the inferior and posterior chondrotomy were implanted into the palate. The idea for stabilization of the soft palate with autological cartilage was taken from The Pillar Procedure, where alogenic implants are inserted in the middle of the soft palate by special pistol. 27 patients from 27 to 64 years of age were operated upon. 70% of them were males.

The indications for surgery were set after endoscopic and functional assessment of the upper respiratory tract, Müller's test, questionnaires, visual-analogue scale /VAS/ and polysomnography in patients suspected for obstructive sleep apnea.

The results of the surgical treatment were measured by functional assessment of nasal breathing-rhinomanometry, AHI, snoring index and VAS. Improvement of snoring was found in 82% and of nasal breathing in 86% of the patients 6 month after the operation.

It is concluded that the described method could be used successfully in well selected patients.

WEDGE RESECTION IN RHINOPLASTY

Petko Kabakchiev

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The technique of wedge resection of the lateral bony wall of the nose was first described by Joseph in 1907. Despite of the logic of the procedure and the easy to do, wedge resection is not often practiced. In our presentation we would like to promote this easy to do procedure once again, in severe asymmetry of the bony pyramid.

To allow repositioning of the deformed nose, the bony pyramid is detached by osteotomies from the frontal bone and the maxillary bones. This is

accomplishing through a combination of different interconnecting osteotomies. The rhinoseptoplasty is usually standard surgical procedure, this way routinely bilateral paramedian (median), lateral and transverse osteotomies are performed. Generally mobilization and repositioning of the pyramid also require mobilization and correction of the septum, septal osteotomies as well.

There may be exception to this standard procedure, depending upon the patient's pathology

and surgical goals to be achieved. If a limited amount of narrowing of the pyramid is required, it is sufficient to perform two oblique osteotomies. In severely deformed broad nasal bony pyramid on the other hand extra osteotomies-intermediate may be added.

After bony pyramid and septum have been mobilized, to narrow the external nose the surgeon has to do bilateral infractions. In some cases one of the sides of the bony pyramid is long, and plain lateral osteotomies are not sufficient to produce symmetry with the infraction. The technique of

choice is the wedge resection of the lateral bony wall of the nose. The technique requires some changes in all stages of the surgery, including Septoplasty where a wedge could be removed too. Mobilization and lowering of the septum with a horizontal (or vertical) wedge resection is an essential part of the technique.

Unilateral wedge resection allows rotation of the pyramid; bilateral wedge resection (introduced much later in 1970) is an effective method of lowering a prominent nasal pyramid.

BACTERIO-THERAPY IN HUMAN RHINOPHARYNX: AN UPDATE

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In recent years, probiotics have been used as a treatment to promote oral health; they have a fundamental role in keeping the balance of the microbial ecology associated with the ability of these bacterial species to interfere during surface colonization. In the oral cavity, *Streptococcus salivarius*, a non-pathogenic and predominant oral species, is able to coexist in the same environment and reduce the frequency of colonization of the main pathogens involved in upper respiratory tract infections. The aim of the present study was to test the safety, tolerability and the rhinopharynx colonization of *S. salivarius* 24 SMB already characterized as not virulent, not antibiotic resistant, possessing the ability to inhibit *S. pneumoniae* and *S. pyogenes*, and adhering *ex vivo*. Indeed showing promising properties as oral therapy, the clinical trial protocol of a nasal spray formulation of *S. salivarius* 24 SMB was conducted on healthy volunteers to evaluate the safety and the ability to colonize and persist in the upper

respiratory tract. The study, still ongoing, enrolled 8 patients: the formulation was given for 3 days after azithromycin treatment and the presence of *S. salivarius* 24 SMB was determined after 2 h, 4 h, 24 h, 2 days and 7 days from nasal spray administration plating nasal swabs for each time onto Mitis Salivarius agar (MSA). Our results demonstrated: i) the absence of adverse effects for all subjects enrolled, and ii) the capability of *S. salivarius* 24 SMB to persist in rhinopharynx tissue in 6 subjects after 6 days from the last dose of formulation with a density of approximately 10^5 CFU/ mL. These results were obtained by analysis of each α -haemolytic streptococci isolated on MSA using molecular identification for correct ID, antagonism tests to evaluate BLIS production and RAPD-PCR to distinguish *S. salivarius* 24 SMB's genotype from other *S. salivarius* strains. The nasal spray was well tolerated in all these patients. These preliminary results confirm that *S. salivarius* 24 SMB is safe and could be used for bacterial-therapy.

ENDOSCOPIC FRONTAL SINUSOTOMY

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Our personal philosophy follows the principles of the limited removal of the so called prechambers in the anterior ethmoid (according to Stammberger). The first step is commonly the partial resection of the uncinate process, that opens the infundibulum. Removal of the uppermost attachment of the uncinate, laterally bent, the cap of the terminal recess, blind end of the infundibulum, in the majority of cases, clears the frontal recess and the frontal ostium ("uncapping the egg"). Less frequently, it is also necessary to remove the dome of one or more frontal cells above and behind, in order to provide enough view of the frontal ostium. Partial removal of cells in the frontal recess area may result in stenosis. The bony bridge between the frontal ostium and the supraorbital ethmoid cell should be

completely removed. If present, an interfrontal sinus septal cell must not be mistaken for the true frontal sinus. The basal lamella of the ethmoid bulla has resulted to reach and to be frequently attached onto the skull base and, then, it defines the posterior boundary of the frontal recess. Removal of the bulla lamella, when it reaches the skull base, exposes the suprabullar and retrobullar recesses and the anterior ethmoid artery, located on the roof. Stepwise and precise identification and removal of the anterior ethmoid cells encroaching on the frontal recess and initial preservation of the bulla lamella (intact bulla technique) allow to follow the natural frontal sinus outflow tract during the dissection, reducing the risk of disorientation, incomplete removal of the obstruction, bleeding and skull base injury.

FESS IN THE TREATMENT OF THE DISEASES OF THE NOSE AND SINUSES - 5 YEARS EXPERIENCE, 450 CASES

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Objectives: with the technical development and the evolution of the pathological concepts for the diseases of the nose and sinuses, the functional sinus surgery is increasingly going into practice and is proving to be a safe and effective method of treatment by replacing the open surgical procedures. We present our five-year experience in treating diseases of the nose and sinuses with the use of functional endoscopic sinus surgery.

Materials and methods: retrospective analysis of 450 patients with diseases of the nose and sinuses that have undergone FESS procedures in the Department of Otorhinolaryngology-MMA-Sofia.

Results: excellent relief of the symptoms has been achieved with minimal invasiveness, rapid recovery and with extremely rare and mild operative complications.

ETIOPATHOGENESIS OF THE NASAL DEFORMITIES

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The nasal septum has caused much debate in ENT, much of it focussing on its significance in contributing to nasal obstruction, with the subsequent need for large proportion of ENT surgical intervention.

The object of our presentation is to present and discuss our opinion concerning the etiology and pathogenesis of the deformities of the nasal septum and external nose. The idea was to determine the reasons for the deviations, as well most of the literature on the topic underline trauma in a different stages of the life as a main cause.

The method was careful evaluation of the available CT and MR images of the head of patients (all age groups) visited the Department of Radiology of our University Hospital with different complains, diagnosis and pathology findings.

The growth phase of the nose may be divided into the following more or less arbitrary periods: prenatal, neonatal, childhood and pubertal.

The developmental phase is the period of

embryonic life (from the third week to the third month after conception) in which the nose and related structures are formed maxillary and mandibular processes begin to develop, at about the third month formation of the nose, maxilla and mandibula is completed. The septum develops from the medial wall of the nasal capsule, between the seventh to eight week and second to third month of embryonic life. At the birth the vomer, maxillary crest and palatine crest are bony. After birth the posterior part of the septum gradually ossifies from cranial to caudal and from caudal to cranial. The septum in particular its anterior part demonstrates rapid growth in neonatal life and early childhood; its growth then gradually slows down. Growth of the perpendicular plate continues at a fast pace until age 10 years. At puberty the process of ossification has reached the vomer.

Our discussion is related with the embryology, growing process of the nose and the different radiographic findings in patients.

FUNGAL RHINOSINUSITIS

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The interaction between fungi and humans shows in paranasal sinuses quite different aspects. Dramatic clinical manifestations have been described, but we know also mild and paucisintomatic clinical entities, and “saprophytic” colonization too. The pathogenesis of diseases as allergic fungal rhinosinusitis and eosinophilic fungal rhinosinusitis are yet occasion of controversies, but also that particular entity that

the fungus ball is. The fungi are ubiquitous: so why only relatively few subjects, immunocompetent, develop a fungal disease?

Our retrospective study, take in account the rhinosinusitis cases of our ENT Department in the years 2007-2011: we focused mainly on patients presenting fungus balls a quite well defined clinical entity, on epidemiology, clinics, imaging, and post surgical follow up.

COMPUTED TOMOGRAPHY IN CHRONIC RHINOSINUSITIS

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Chronic rhinosinusitis (CRS) with or without nasal polyps (NP) has shown high prevalence and significant impact on the health care economy. Computed tomography (CT) is the imaging modality of choice. Magnetic resonance (MR) is better reserved for differentiation of mucosal thickening from retained secretions and tumors from inflammatory diseases. Diagnosis of CRS is clinical, based on symptomatology, duration of disease (history), physical examination and endoscopic signs, and CT should be evaluated only in conjunction with the clinical findings for confirming and corroborating the inflammation. CT contributes especially to diagnosis of bone changes/involvement (thinning, erosion in NP; thickening, sclerosis, sign of osteitis: localized at a

tumor origin as in inverted papilloma, or diffuse as in CRS or previous surgery) and to diagnosis of associated coexistent diseases such as mucocele, pyocele, fungus ball (iron like), tumors, meningocele, meningoencephalocele, CSF leak. From the international literature, there are discrepancies and lack of statistically significant correlation between symptoms severity and CT scan severity. Patients with a diagnosis of CRS based on symptoms may have negative CT scan and viceversa, patients with negative symptom based diagnosis of CRS may have positive CT scan. An higher CT score with completely opacified sinuses do not correlate with more severe symptoms. No correlation exists between opacification of specific regions on CT and areas

of facial pain or pressure. CT should be considered only if medical treatment fails and prior to decide surgery. The usage of triplanar information of high resolution CT scans is mandatory in evaluating the complex ethmoid anatomy, especially the frontal recess area. CT can provide reconstruction of three dimensional picture of the anatomy and drainage pathways of the sinuses ("building block concept" by Wormald). The future is 3D reconstruction and

analysis of sinonasal anatomy. In conclusion CT is a poor diagnostic tool for crs and it should be requested after failure of maximum medical treatment for confirmation and staging the extent of disease. CT provides a surgical map showing the details of the bony anatomy. Close cooperation between radiologist and otorhinolaryngologist is crucial for a correct method of reading, proper interpretation and productive decision.

ENDOSCOPIC SURGERY FOR MALIGNANT TUMOURS INVOLVING THE NOSE, PARANASAL SINUSES & SKULL BASE

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Malignant sino-nasal neoplasms are rare pathologies, accounting for less than 1% of all head and neck cancers. Treatment of these tumors is based on surgery, traditionally performed through trans-facial approaches or anterior craniofacial resection (CFR), combined in advanced stage lesions with adjuvant radiotherapy (RT). During the last 15 years, trans-nasal endoscopic surgery has been extensively used to manage small/intermediate stage tumors. More recently, the possibility to achieve endoscopic resection of the anterior skull base (ASB) and overlying dura, with subsequent repair of the defects, has further advanced the adoption of endoscopic technique. The aim of this lecture is to explain the main surgical steps in endoscopic tumour removal and to review our experience in the management of sino-nasal and skull base tumors during a 15-year period in our Institution, with special emphasis on the evolution of surgical strategies toward minimally invasive approaches. Our study included a retrospective analysis of patients treated for sino-nasal and skull base

malignancies from 1996 to 2010, managed by the surgical team at the Departments of Otorhinolaryngology of the University of Insubria-Varese and Brescia. Data was retrieved from a database dedicated to neoplasms of the sino-nasal tract. There were 320 patients considered eligible for the study. An exclusively endoscopic approach was performed in 260 cases: 137 patients underwent endoscopic resection (ER) and 123 underwent ER with trans-nasal craniectomy (ERTC). The remaining 60 cases underwent a combined cranio-endoscopic resection (CER). The commonest histological diagnosis included adenocarcinoma (42.9%), squamous-cell carcinoma (10.5%), olfactory neuroblastoma (10.5%), mucosal melanoma (8%), and adenoid cystic carcinoma (5.2%). Overall, 158 (48.7%) patients received some form of adjuvant treatment. The follow-up ranged from 1 to 168 months. The 5-year disease-specific survival in this cohort was almost comparable to external approaches. To the best of our knowledge, this is the largest series reported to date of malignant tumors of the

sinonasal tract and adjacent skull base treated with pure endoscopic or cranio-endoscopic techniques. These results combined with short hospitalization, due to a very limited morbidity typical of mini-invasive procedures, seem to indicate that

endoscopic surgery, when properly planned and in expert hands, may be a valid alternative to standard external surgical approaches for the management of malignancies of the sinonasal tract.

EXTERNAL APPROACHES TO MAXILLO-FACIAL MALIGNANCIES

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The aim of our study is compare the external and intranasal approaches to the maxillo-facial complex for treatment of malignancies, showing the limits of intranasal approach and pointing the advantages of external one.

Through the last decades the intranasal approaches, originally developed for treatment of benign pathology of nose and paranasal sinuses, has more great useful also in treatment of malignant lesions of maxillo-facial complex.

This approach has his best advantages in a limited morbidity and in a few days of hospitalization. On the other hands this approach has many limits.

Most of all the less surgical exposure than open surgery, but also more difficult in access of particularly region of maxillary complex (especially the lateral and posterior wall of maxillary sinus as well as the lateral portion of

frontal sinus). Moreover most of authors in literature agree in considering the invasion of orbit, palate, dura and the extra nasal/sinusal invasion as a contraindication for intranasal approach.

For this considerations the external approaches still largely used to treat malignancies of maxillo-facial complex.

With this approaches the survival rate at 5 years vary in literature from 25% at 65%. The most common of these are paralateronasal (also extended) approach and midfacial degloving approach. The last one is more effective when an open wide field is necessary especially when it's needed a combined ENT-neurosurgical approach and it give more acceptable aesthetic results. If the malignant extended to the lateral space of maxillo-facial complex it can be useful to use an infratemporal way (type C) to achieve the tumor.

COMPARISON OF SINUS SURGERY FOR NASAL POLYPOSIS WITH CONVENTIONAL INSTRUMENTATION AND MICRODEBRIDER

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Nasal polyposis (NP) is a chronic inflammatory disease considered as a subgroup of chronic rhinosinusitis according to the classification of Fokkens et al (2007).

Nasal polyps arise from the osteo-meatal complex and have a centrifugal and multidirectional growth that may involve every nasal sinus (Wigand & Hosemann 1989).

Functional Endoscopic Nasal Surgery (FESS) is the therapeutic gold-standard when the pharmacological therapy fails (Levine 1990, Kennedy 1992, Smith et al. 1993).

The surgical aim is to eradicate polyps, to restore nasal ventilation and to prevent recurrences preserving as much as possible the integrity of the respiratory mucosal layer (Senior et al 1998, Holmstrom et al 2002, Watelet et al 2004, Fokkens et al 2007, Sauer et al 2007).

The endoscopic surgical technique first described by Messerklinger and Stammberger promote the use of manual instruments as the cutting forceps to perform a controlled mucosal resection (Messerklinger 1978, Stammberger 1986); thereafter Setliff and Parsons applied powered instruments as the Microdebriders in

sinonasal surgery (Setliff & Parsons 1994, Setliff 1995, Ferguson 1999).

Powered instruments perform a continuous suction/irrigation, improve visualisation of the surgical field facilitating controlled resections and reduce mucosal damage, allowing a quicker mucosal recovery and less tissue trauma (Bernstein et al 1998, Setliff & Parsons 1994, Krouse & Christmas 1996).

At the opposite, conventional surgery performed using Blakesley forceps work stripping the mucosa with more radicality but, at the same time, increasing the risk of bone exposition; consequently the reepithelization occurs slowly and is more frequently associated with formation of sinechiae (Bernstein et al 1998, Selivanova et al 2003).

The introduction of a new instrumentation in FESS emphasizes the question of which approach is the best in terms of therapeutic effectiveness.

The aim of the present perspective single-blind randomized study is to compare the recurrence rate in function of the surgical instrumentation used for the surgical treatment of NP: Microdebrider vs Blakesley forceps.

PARALLELISM IN OTOSURGERY AND SINUS SURGERY

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Ear surgery is mainly done with fine instruments with the help of the microscope and has been recognized as one of the most delicate surgeries. This finesse has permitted the passage from otosurgical to otoneurosurgical and skull base procedures and many ENT's are among the best surgeons worldwide in this field. The same finesse is necessary for nasal surgery using Functional Endoscopic Sinus Surgery (FESS); in fact, there is so much of similarity between the middle ear cleft and paranasal sinuses. There is a nerve to take care of, facial nerve and optic nerve. The periorbit as a landmark may be compared with the lateral sinus and the jugular bulb. Dura mater and carotid artery are present at the limits of both structures. The ear and the sinuses are well

pneumatized and blocking of aeration may be a cause of disease. The trans-labyrinthine approach to the cerebello-pontine angle for the removal of an acoustic tumor may be compared to the nasal route to hypophysectomy or removal of tumors of the clinoid. Orbital decompression has affinity with facial nerve decompression while endolymphatic sac shunt may remind marsupialisation of the lacrimal sac for dacryocystitis secondary to blockage of naso-lacrimal duct. Both otologic and endoscopic sinus surgery are better done only after diligent study of anatomy and hands-on cadaver dissection. The parallelisms present in this two surgical fields makes them so interesting to be mastered by the same ENT surgeon.

ENDOSCOPIC DACRYOCYSTORHINOSTOMY

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Dacryocystorhinostomy is indicated in patients with chronic obstruction or stenosis of the sac or of the nasolacrimal duct when pathologies such as epiphora or recurrent dacryocystitis cause severe discomfort to the patient.

All patients had been assessed by an ophthalmologist and had had repeated sac washouts, which failed to improve their symptoms.

If the obstruction is in the puncta or the canaliculus endonasal DCR will not help.

External DCR is the conventional technique but with high morbidity, endoscopic DCR reduced morbidity and has the same success rate.

The success rate of EDCR is comparable to the external approach and it has many advantages: minimally invasive procedure, better aesthetic result with no cutaneous scars, it preserves the lacrimal pump system, faster resumption of normal daily activities, any intranasal pathology that might have caused obstruction can be addressed, active

infection of the lacrimal system is not a contraindication to surgery, it is much less bloody than the external approach, the perioperative time is shorter. The disadvantages are: possibility of orbital hemorrhage from the anterior ethmoid artery during the endoscopic procedure, possibility of orbital fat herniation and subcutaneous emphysema, 2 operators (ENT and ophthalmologist)

Before the operation the instrumentation and the patient have to be prepared and the surgery times organised (ophthalmologist and ENT).

We use endoscopes 4 mm 0° and 45°, pediatric endoscopic instruments, high resolution videocamera, microdrill, microdebrider, fiberoptic light probe (0,9-0,5 mm).

The head of the patient is elevated in the anti-Trendelenburg position (15-20 °). The nose is packed with a solution containing epinephrine and xylocaine to induce local haemostasis; the packing is left there for 8-10 minutes. Then we inject the area of the anterior attachment of the middle turbinate using a solution containing carbocaine and adrenaline 1:20000; we use a spinal needle nr. 22. If the procedure is done under local anesthesia we put a coanal packing. The ophthalmologist then dilates the punctum of the inferior canaliculus and a fiberoptic light probe is used to cannulate and illuminate the lacrimal sac.

A mucosal flap is elevated, exposing the lacrimal fossa (often we drill directly on the mucosa). The bone is drilled out, exposing the medial wall of the lacrimal sac. In this phase anatomical differences are possible: if we have a protrusion of agger nasi cells, we have first to open them or if we have a medial displacement of the uncinat process, we have first to remove it before drilling. The ophthalmologist next introduces a probe tenting the medial wall of the lacrimal sac. The sac is incised, as anteriorly as

possible, to create a neo-ostium so that tears can drain directly into the nose. The ostium is kept open with a tube stent placed through the puncta into the sac and out of the nose. Then we wash with a saline solution at 2°C and we don't need packing.

The tubes are kept in place from four to six months.

The techniques, in our experience, have a very satisfactory surgical result that is comparable if the mucosa covers all exposed bone and we make a large epithelialized fistula to avoid granulation tissue or synechia that are the most common causes of surgical failure in DCR. We make a large ostium by removing a piece of bone about 6-8 mm in diameter, because after the surgical bony opening, it has been shown that the healed ostium does not remain as large as the initial bony opening. It is necessary to preserve the nasal mucosa and to put the flaps on the bare bone to create an anastomosis between the nasal and the sac mucosa. It is very important to make the ostium at the level of the common canaliculus, so tears then flow directly into the nose; if the fistula is too low it may not bypass an upper obstruction; if the fistula is too high tears may flow against gravity and stagnation may induce local infections. The success rate is similar to the success of external DCR (90%). The endonasal laser DCR procedure using the KTP has the same success rate (90%). Intraoperative topical Mitomycin-C had also been used by many surgeons to prevent granulations but its efficacy is not conclusive.

We use always stents to keep the ostium open but when the mucosal sac flap is everted there is a possibility for obtaining wide ostium without tube stenting.

CORRECTIVE RHINOPLASTY IN CONGENITAL UNILATERAL AND BILATERAL CLEFT LIP AND PALATE

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Objectives: Cleft lip and cleft palate are the most common birth defects. Patients with congenital unilateral and bilateral cleft palate and lip are subject to a number of planned surgery. Despite the significant optimization of the operational age and improvement of operational methods with age occur several secondary disturbances. These are the residual deformation of the external nose and inner structures. The nose is one of the most affected organs in congenital unilateral and bilateral cleft palate and lip and the question of its correction is essential. Secondary nasal correction

in a different volume is almost always necessary.

Materials and methods: Retrospective congenital unilateral and bilateral cleft palate and lip between the ages of 16 and 37 years.

Results and conclusions: The corrective rhinoplasty of residual nasal deformities in unilateral and bilateral congenital cleft palate and lip significantly improved respiratory function and the external symmetry of the nose in the patients studied. This surgery is usually the final of the multiannual program for the treatment of patients with congenital defects.

PRE-AND POST-OPERATIVE THERAPY IN ENDOSCOPIC SINUS SURGERY FOR CHRONIC RHINOSINUSITIS

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The common pre-op and peri-operative systemic medications are basically antibiotics and corticosteroids. Antibiotic treatment is considered imperative in case of purulent discharge and even when nasal packs or stents are used. However, an antibiotic preoperative therapy, more than prophylaxis, is almost always recommended, because this surgery is contaminated and, mainly, in order to improve the conditions of the surgical field and thus reducing inflammation and bleeding

and risk of complications. The prophylaxis may start 1-2 weeks before and should be based on the results of sinus cultures, even if it is routinely and mostly empirical. Systemic corticosteroids reduce inflammation, risk of bleeding, oedema and the size of the polyps and, therefore reducing surgical time and risk of injuries. Short course of systemic steroids before the operation are recommended, especially in severe nasal polyposis, such as in ASA triad. Postoperative protocols vary widely

among surgeons and studies. Surely, it has to be diversified according to the nature and extent of pathology. The same day of the operation or after removing the packing, the operated nasal cavities would need to be daily cleaned by nasal watery and saline solutions, sprays, douches or irrigations, for moistening until the clots and crusts subside. Patients are advised to repeat it twice or more times a day for weeks. It is essential to give patients information, instructions and counsel about late complications and nasal hygiene. Post-operative wound care is a matter of debate. Local steroids are usually given, even starting soon after the operation. Since the probable role of immunopathological factors, many studies have

described benefit from post-operative topical steroids on nasal symptoms and on polyp recurrence. Atopic patients with nasal polyps should take antihistamines for several months, though in chronic rhinosinusitis has been found no evidence of benefit. In the absence of pus, the use of antibiotics is questionable. Diffuse polyposis requires often systemic steroids at intervals. In ASA triad patients, additional therapy with antileukotrienes is suggested. Symptoms do not help in follow-up, and asymptomatic postoperative complications may be discovered only by endoscopy. Postoperative CT is recommended only in case of need of revision.

OWN METHOD FOR STRENGTHENING THE NOSE TIP AND COLUMELLA

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Objective: Most of the methods described in the literature to enhance tip of the nose and columella give insufficient satisfactory functional and aesthetic results. The proposed and used by us own surgical method aims to simultaneously strengthen columellar stability, lift nose tip and wing and improve nostril symmetry.

Materials and methods: Retrospective analysis of surgical treatment in 100 patients, 41 of

whom had congenital unilateral or bilateral cleft palate and lip. Operative technique is based on the use of bone - cartilage avtotransplantant representing a fragment of nasal back, which is implanted in the nasal tip.

Results and conclusions: Our methodology gives excellent aesthetic and functional postoperative results and allowing us to use it routinely in practice.

NASAL TIP SURGERY

Plamen Nedev

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Control of nasal tip contour has always been a key component of a successful rhinoseptoplasty. The nasal tip surgery is an integral part of rhinoseptoplasty. The goal of the nasal tip plastic surgery is to reduce or increase, change the shape or and projection, rotation and contour the tip. We present a new technique for the reduction and lifting of the nasal tip with a proportional reduction of the alar cartilage and suture technique - cranio-caudal transdomal sutures. The purpose of the presentation is to show our experience in this field and to describe our own version of suture

technique. Using suture techniques along with excision of the alar cartilages permits a more radical change of the nasal tip. The cranio-caudal transdomal sutures give the chance not only to narrow the nasal tip, but also to rotate it. The rotation is considerable and controlled in 70% of the cases with this suture technique. The controlled positioning of the nasal tip depends on the position of the cranio-caudal transdomal sutures and their tightening. Cranio-caudal transdomal sutures are highly effective and easy to be performed.

MANAGING OF THE DEVIATED NOSE IN THE RHINOSEPTOPLASTY

Frodita Jakimovska

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Correction of the deviated nose is one of the most challenging areas in rhinoplasty. The deviated nose represents a complex of aesthetic and functional problem.

The nose can be thought of as being divided into three parts including: top third, middle third and bottom third. The top third is bony part of the nose, the middle third is bridge-made of cartilage, and the bottom third is the tip of the nose. Deviated noses are often due to nasal bones being pushed in one direction or another. Generally, this is due to trauma. Osteotomies or nasal bone fractures are often needed to straighten the deviated portion of the nasal bones. Although many patients seek surgical repair for deviated noses because they are

self-conscious, a twisted nasal bridge can impact breathing and airflow through the nose. Septal surgery plays a central role in the successful management of the externally deviated nose. A deviated nasal septum should be corrected at the same time as a deviated nose for better long term aesthetic and functional breathing improvement. Cartilage grafting is often necessary in the collapsed areas of the cartilaginous portion of the nose to give a straighter looking nose.

Structural principles and surgical anatomy will serve as the foundation, emphasizing the areas in the nose in which the intersection of form and function are most important.

FESS IN THE TREATMENT OF MAXILLARY SINUSITIS OF DENTAL ORIGIN

Hristo Zlatanov, Samuil Milev

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Objectives: 12% of the maxillary sinusitis is of dental origin. It often remains undiagnosed and its improper treatment leads to recurrence and complications. They have a polymicrobial mixed aerobic and anaerobic etiology and are often complicated by oroantral fistulas, material from endodontal treatment or dental implants. We present our experience with 12 patients with

maxillary sinusitis of dental origin.

Materials and methods: retrospective analysis of treatment with functional endoscopic sinus surgery of 12 patients with maxillary sinusitis of odontogenic origin. Treatment was in collaboration with a dentist.

Results: treatment achieved disease cure with minimal invasiveness and quick recovery.

OUR EXPERIENCE WITH SINONASAL INVERTED PAPILLOMA. PRESENTATION OF THREE CLINICAL CASES

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Sinonasal papillomas are defined as "benign epithelial tumours of the sinonasal mucosa, composed of an exophytic or endophytic proliferation of columnar and/or squamous cell, with mild to moderate atypia and without stromal invasion". They are uncommon clinical presentations, representing only 0.4-4.7% of all sinonasal tumours. On anatomic basis Batsakis in 1979 divided them into four varieties- inverted papillomas arising from the lateral nasal wall (62%), fungi form papillomas arising from the nasal septum (32%), cylindrical papillomas arising from the paranasal sinuses (6%) and keratinising squamous papilloma arising

from the nasal vestibule (frequency unknown). Papillomas are very common presenting in adults between 30-50 years of age. Men are affected twice as often than women. Nasal obstructions the most common symptom and is usually unilateral. Local excision can often lead to local recurrence in 50-70% of cases, usually within 1-2 years. The length of the periods between relapses are not correlated with the risk of subsequent transformation into malignant disease-cancer. Human papilloma virus (HPV) has been identified in inverted papillomas and fungi form papillomas. We present three clinical cases from our practice.



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It publishes original ENT works, notes of actuality, critiques, editorial columns, associative news and abstracts of meaningful scientific articles.

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Storia dell'Associazione

Il 18 Maggio 1989 è stata costituita l'Associazione Italiana Otorinolaringoiatri Libero Professionisti (A.I.O.L.P.) affiliata, dall'anno successivo, alla Società Italiana di Otorinolaringoiatria e Chirurgia Cervico-Facciale (S.I.O. e Ch.C.F.). L'A.I.O.L.P. ha l'obbiettivo di riunire ed organizzare tutti gli Specialisti in Otorinolaringoiatria liberi professionisti; come tali sono considerati i Colleghi che non hanno in essere rapporti di dipendenza con Università od Enti Ospedalieri, cioè libero professionisti puri, convenzionati esterni con il Servizio Sanitario Nazionale od altri Enti, specialisti ambulatoriali, consulenti ospedalieri, termalisti, medici militari, specialisti O.R.L. di fabbrica, convenzionati o dipendenti di A.S.L. (Azienda Sanitaria Locale) e di Case di Cura, ex universitari ed ex ospedalieri. Coloro che pur non possedendo i requisiti di Socio desiderino partecipare alla vita associativa, possono iscriversi come "Sostenitori A.I.O.L.P." senza diritto di voto all'Assemblea dei Soci né eleggibilità alle cariche sociali.

L'A.I.O.L.P. mira a tutelare il prestigio della figura dell'Otoiatra Libero Professionista, a valorizzarne la qualificazione ed a promuoverne e sostenerne in modo permanente la formazione.

Story of the Association

The Italian Association of the free-lance professional Otologists (A.I.O.L.P.) was constituted on the 18th of May 1989. The very next year it was affiliated to the Italian Society of Otorhinolaryngology and Cervical-Facial Surgery (S.I.O. and Ch.C.F.). The purpose of A.I.O.L.P. is to assemble and organize every free-lance E.N.T. Specialists. For free-lance we mean those Colleagues who are not Hospitals or University's employees but just free-lance panel professional Specialists of the National Health Service, Boards, out-patients department Specialists, Hospital's Consultings. Specialists who work in the Baths, Medical Officers, E.N.T. Specialists working in factories, Hospital's panel Doctors, A.S.L.'s (Local Health's Business) employees, Specialists who work in Nursing Homes, former University and Hospital's specialists. Should somebody have not the necessary requirements to become a Member but still desires to take part in the social life of the Association can be enrolled as "A.I.O.L.P. founder member" but with no right to vote during the Members' meeting or to be eligible dignitary.

The aim of A.I.O.L.P. is to safeguard the role of free-lance Otologists, to enhance their qualification as well as to back or permanently promote their training.

