INTRODUCTION
Welcome to the University Hospital, Geelong, continuing your training career in Otolaryngology. The ENT registrar at the Geelong Hospital is in the unique position of being the only accredited trainee at a Non-Metropolitan Victorian hospital. As such there is exposure to the wide range of Otorhinolaryngological and other medical opportunities, without the restrictions of a large Melbourne hospital.

DESCRIPTION OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
Otolaryngology-Head and Neck Surgery is a specialty concerned with the medical and surgical treatment of the ears, nose and throat and related structures of the head and neck. The speciality encompasses cosmetic facial reconstruction, surgery of benign and malignant tumours of the head and neck, management of patients with loss of hearing and balance, endoscopic examination of upper aerodigestive tract and treatment of allergic, nasal, sinus, laryngeal, thyroid and oesophageal disorders.

UNIVERSITY HOSPITAL, GEELONG
The University Hospital is a 406-bed acute General Teaching Hospital servicing a population of 250,000 people in the South Western Region of Victoria, with more than 65000 inpatient admissions and 62000 emergency attendances per year. There is a full range of medical and surgical specialities provided by the Hospital. There are Professorial Units in Medicine and Surgery and a Clinical School attached to Deakin University.

SURGEONS
Mr Russell Calder - 42 Swanston Street Ph. 52222768, 0408524831 russellcalder@ncable.net.au
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Mr Tim Connolly - 0411035857, timothyent@gmail.com
Make use of regular email for notification of theatre changes, weekly meetings and any other matters. Text messaging also is encouraged by some!

**JOB DESCRIPTION**

The ORL registrar is responsible for the day-to-day running of the hospital ORL Department.
The registrar is expected to attend to all public patients - supervising all admissions, authorising medications and arranging surgical management.

The ward patients must be seen every day, with clear progress notes documented as appropriate. It is best that a regular daily round is performed with the ORL team to provide continuity of care during the day. All treatment decisions should be relayed to the Nurse-In-Charge of the ward, preferably both by mouth and in writing.
Discharge planning is essential via liaison with the appropriate paramedical services. The registrar must see that the discharge information has been completed in detail before discharge.
The Registrar should be aware of private patients admitted to the hospital and should be involved in their management as this is an important access to further medical exposure.

The Registrar must organise the Operating Schedule of the Department. This involves scheduled public, private, mixed, semi-elective and emergency lists. It is important to regularly review the available operating space for cancellations and additions. The extent of forward planning required will vary but up to 6 weeks notice is necessary. Lists must be checked with 'Rooms' secretaries to co-ordinate the bookings, especially mixed lists.
The duration of operations should be checked with the supervising surgeon unless otherwise stated. It is important that lists are not regularly overbooked. Special requirements must be notified to theatre.
The waiting list office is in theatre (Phone 51623).

The operating lists (and public/private allocation) must be confirmed with the surgeons (or better, with their staff!). It is important to check the lists regularly for changes.

It is best to obtain master copies of the operating schedule from the theatre suite as this will be the most accurate guide.

The Registrar must attend all outpatient clinics, unless required in theatre.

There are also registrar-only clinics, for review and peri-op assessments.
For the Head and Neck MDM you need to notify Andrew Love of patients to be discussed by midday Monday and a text should be sent out to the MDM team as to whether a meeting is going to be held.

Thyroid/Endocrine MDM’s occur every 2-3 months on a Wednesday at 12pm. Liase with Shayne Ryan MDM manager to add patients to the list.

During the clinics, the registrar should see both new and review patients, referring all queries to a consultant. The clinic is the ideal place to develop history taking and examination techniques. As much as practical, new patients should be presented to a Consultant. This enables clear thinking and planning to be developed. The clinic also provides the opportunity to learn the techniques of flexible endoscopy of both of the nose, pharynx and larynx. The registrar must check each week with the Andrew Love Centre concerning the H&N clinic and notify the surgeons if there are no patients to be seen. Patients placed on the surgical waiting list should be checked for urgency and managed accordingly. The Registrar-only clinic is provided for routine review of minor registrar cases (e.g. tubes, tonsils etc). If any difficulties arise these should be referred to a consultant by phone or to the next clinic.

Time during the week should be allocated in the Peri-Operative Clinic to pre-assess up coming surgical patients. Currently this occurs every Thursday morning. This commences at 9am followed by a nose fracture clinic at 11am for manipulation under LA.

The weekly Grand Round occurs Friday at Birdsey 5. All Unit doctors and medical students if on rotation attend this. A Speech Pathologist also attends and should be informed of the time. The time varies (7.30-8.00) depending on postgraduate meetings.

There is a fortnightly postgraduate education meeting as per the attached program.

The Emergency Medical Department should be supported at all times. This means attending to all referrals as soon as possible or making other arrangements, e.g. outpatient appointments, consultant referrals. Emergency admissions should be notified to the Consultant-on-call. Other referrals should be treated on their merits. There should be NO hesitation to ask for an opinion or for a Consultant visit.

The Otolaryngology Registrar is on call alternative weekdays and alternate weekends. The weekend cover will alternate with the ORL non-accredited Registrar. The entire year roster should be created at the commencement of the year. The weekend on-call can be flexible and when altered, the consultant-on-call MUST be notified. It is important that alterations DO NOT overload either of the registrars. It
is the Registrar's responsibility to make sure that the hospital switchboard, the EMD and the ward are aware of the On-Call situation. Annual leave should be taken during the year. Please notify hospital administration of your intended leave (annual and conference) for 2016 before commencing.

The ORL Registrar must work closely with the allocated resident and non-accredited Registrar. Apart from supervising the day-to-day work of the resident, the Registrar is responsible for training the resident in the basics of ENT diagnosis, examination, surgical consent and general management. At the end of their term the resident should feel comfortable to discuss most common problems and to manage routine situations. The resident will be shared with FMS and Ophthalmology, with the bulk of their roster involving ENT. The Registrar must ensure a fair distribution of workload with the non-accredited Registrar, bearing in mind that the accredited Registrar has first choice of surgical cases and should take FULL RESPONSIBILITY for decisions of the team.

The ORL non-accredited Registrar will be on up to a 6 month rotation.

An important component of the work in the unit involves supervision and instruction of the medical students on rotation. The registrar may be asked to be involved in both formal and informal teaching. There will be a lecture to the students at the university later in the year.

The Registrar will also be required during the year to participate in the continuing education of other groups within the hospital, including nursing staff and the EMD. This is a valuable part of the post as it is an excellent way to consolidate ongoing study and to lift the profile of the speciality.

The following is a useful guide which can be distributed to the junior staff during the year.
ENT Handbook for Emergency and Junior Staff

EAR:

**Foreign Body – EAR**
Common occurrence especially in children, often an incidental finding. Be careful with organic matter that may swell – oat seeds, or wheat
**BATTERIES*** Must come out CALL REGISTRAR
Management
Tips for removal – wrap children in blanket, first attempt best attempt, get headlight and equipment wax curette, hook etc.
Review
Referral to ENT Registrar for review in clinic or in emergency at reasonable time.
GP review if removed and concern re laceration on canal.

**Ear Wax:**
Common problem especially in hearing aid wearers. Wax is normal part of ear.
Start by attempting removal with wax curette. If difficult patient then consider softening and dissolving agents prior to removal
Management:
Soften – Olive oil, vegetable oil, waxol, ear clear
( **Ensure NO Drum perforation **) Dissolving – 3 % Hydrogen peroxide 1-3 ml in ear bd – use 5 ml syringe and small plastic tube to instil into ear ( Instructions included)
Review
GP as needed

**Ear - Otitis Externa**
Generally presents as itchy discharging and often painful ear. Often history of water exposure, swimming pool or recent syringing by GP.
Mild – swelling and debris external deep canal only
Mod – swelling and debris in external canal and some mild - mod pinna swelling
Severe – gross swelling of external canal and pinna with cellulitis and distortion.
Management:
Adequate ear toilet with sucker ( Green sucker and white adapter from theatre)
SEND MC&S SWAB PLEASE
Keep ears dry
1-2 ear wicks in canal as far as drum ( in draw in EMD and on BW5)
Ear drops while the wick is in position. Wicks stay in up to a week at a time, if fall out it is ok as the swelling is going down.
Drop choice:
Sofradex 2 ear TDS ( If not previously happened and no prior Rx by GP)
Ciproxin HC 2 ear TDS ( If previous Rx and / or Diabetic
If severe call ENT reg and consider admission for IV antibiotics.
Review
ENT clinic 2-3 days after wicks inserted.
**Ear - Otitis Media**

Very common condition usually well managed by GP’s. Once ear has perforated pain usually settles.

Management:
- Prior to perforation oral antibiotics
- Amoxicillin first choice
- Post perforation – Keep ears dry 2 weeks
- Use topical treatment to get the medicine to target the infection.
- Ear toilet suction or Peroxide
- Ciproxin HC drops 2 ear TDS 3-4 days. (if using peroxide then wait 30 min after otherwise inactivates the antibiotics.)

Review
- 1st attack – GP
- 3rd or recurrent attacks – 3-6 weeks with audiology in ENT clinic

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**Hearing Loss**

Full History and exam
- Exclude Neurological, Infectious, trauma and local causes
- Track down previous audiology if done
- Get copies of previous ear surgery operations if done elsewhere

Management:
- Call and discuss with ENT registrar
- If sudden onset consider Prednisolone 1mg/kg

Review:
- Audiological assessment and review in ENT clinic PH 7285

**Discharge post grommets:**

Very common, especially when child has a cold. If child well, no pain and the discharge is same color as nose then the grommet is doing it’s job. Just need to ensure it doesn’t get blocked.

If painful and irritated then will need treatment

Management:
- Hydrogen peroxide 3 % 1-3 ml in ear bd – use 5 ml syringe and small plastic tube to instil into ear (Instructions included) to decrease discharge and crusting around grommet.
- Ciproxin HC drops 2 ear TDS 3-4 days. (if using peroxide then wait 30 min after otherwise inactivates the antibiotics.)

Review:
- GP in a week and should already have ENT follow up planned.

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**NOSE:**

**Foreign Body – NOSE**

Common occurrence especially in young children. Can present late with chronic offensive nasal discharge unilateral.

Beads, shells, paper, food etc can generally wait for removal

***BATTERIES CAN NOT WAIT MUST REMOVE****

Management:
- Attempt removal with child restrained
- Cophenylcaine spray 4 sprays, wax curette, hook, sucker etc and appropriate light.
- If child restless then risk more damage may be better to refer to ENT for theatre.
- Review: GP at a week if removed.
- ENT Reg in EMD if unable to remove – get pt to come fasted so can go to theatre if needed.
Epistaxis
Again a common problem worse in winter than summer due to the drier air and lacking humidity.
Mild: troublesome bleeding settles with simple measures. Often multiple attacks of small volume <100ml 4 Tablespoons
Mod: Needs more aggressive management with packing
Severe: Large volume not able to be controlled with pressure, loss >500ml
Management:
MILD:
Sit Patient up
Head forward
Give them a sucker to suck blood from the mouth or under nose
Ice to suck
Cool flannel at back of neck
Apply a nasal bolster
Continuous 10minute of pressure at bone and cartilage junction.
Calm patient down, analgesia etc.
If small point use suction and silver nitrate cautery.
If not settling IV access, full set bloods including group and hold.

MOD: AS Above and then if still bleeding
Consider packing the nose if still bleeding, give analgesia and consider using midazolam but pt must have 02 sat monitor and senior staff aware.
Merocel – place with fingers and ensure push all the way in.
Ribbon Gauze – position with forceps and speculum
Ensure have headlight, sucker and nasal speculum to assist positioning.
Packing should stay in 24-48hours and while in position patient needs antibiotics.
Easily removed the following day in EMD.
CDMU Admission if won’t tolerate packing, if unilateral and <60yo consider DC home and review in EMD.

Severe: As above and then if still bleeding get senior consultant review
Check BP, pain anxiety etc
ENSURE bloods all sent including coags.
Correct coagulation abnormalities.
Call ENT reg for review
On removal of Packing or discharge start all patients on sprays to minimise crusting and moisturise the nose for 2 weeks after presentation.
Nozoil 2 nose TDS
Narium / FESS 4-5 spray nose 4-5 times a day.

Nasal Fracture
Patient regularly present after facial trauma concerned about their nose.
Management:
Ensure no septal haematoma – if present call ENT
Control epistaxis
IF GROSSLY deviated then will need surgical correction if patient wants it. Need to be seen in ENT clinic within 1 week post fracture. NOT A REFERRAL LETTER. RING AND GET A CLINIC TIME. This allows time for swelling to settle and more formal assessment to be made. If over 2 weeks and non tender nose will need a formal rhinoplasty performed and referral to ENT clinic in a less urgent manner.
Review:
ENT clinic within 1 weeks of sustaining injury.
Post septoplasty bleeding:
Not common 2-5% cases.
Mild – severe and may need reoperation.
Rhinoplasty patient will have plaster / dressing on nose and important not to push on bone structures as may be unstable. Septoplasty patients may have splint in nose but are very safe to insert merocel using speculum.
Management:
As for epistaxis and if fail to settle then call ENT Registrar.

Acute Sinusitis:
This is a common problem and generally does not require acute surgical intervention unless severe. Variable presentation, teeth pain, nasal congestion, discharge and face pain. Usually can manage the patient with antibiotics, these may be IV while in emergency and discharge home on orals. If concern re severity call ENT registrar
Management:
Augmentin duo forte 1 o BD
Rulide 300mg o daily
Consider a stat dose of steroid to decongest and start nasal sprays.
Nozoil 2 nose TDS
Narium 4-5 nose QID
Rhinocort 1 nose nocte or Nasonex 1 nose nocte. Oxymetazoline sprays
Review:
If first or infrequent attacks GP review
If recurrent problem needing definitive management referral to ENT service for OP review 4-6 week with CT scan just prior to review in clinic when infection all settled down.

Periorbital cellulitis:
Usually a paediatric presentation but can happen in some adults. Most cases no true cause found and will settle with antibiotics. Rarely need surgical intervention and management by paediatric team with ENT and EYE consult is standard.
Management:
Oral or IV antibiotics based on antibiotic guidelines.
Nasal sprays decongestant and start nasonex to decrease swelling.
If fail to improve after 48hours treatment then do CT / MRI scan looking for sinus opacification and potential abscess that may need drainage.
Review:
No need for ENT review unless recurrent problem.
Paed team review and referral from there if indicated.

THROAT:
Foreign Body – Throat
Common occurrence getting food bolus stuck. The likelihood of something being present is very much dependent on history. If there was no pain at the point of swallow and it came on later unlikely to be true FB stuck, may be oesophageal pouch or other pathology. If fish bone most likely place is junction of tongue and tonsil.
Management:
Try and move the stuck item, bread, drink coke etc.
Try and relax the neck muscle spasm – pethidine and / or diazepam
Protect airway throughout
Attempt removal and examination
Cophenylcaine spray to mouth and then get pt to hold gauze soaked in cophenylcaine in throat on Rampleys forcep to ensure goes numb and to minimise gagging.
If still stuck call ENT for review at reasonable time unless airway compromise.
Review:
If removed or clears in EMD then GP review 2 days to ensure settling and no abscess
ENT clinic after discussion with Registrar.

Tracheostomy:
Determine what type of tracheostomy and why done?
End stoma after cancer surgery versus Plastic tube maintaining airway.
Management: Ensure safe airway.
Use smaller size trach, a NG tube or even ET tube if needed.
Re insert airway that has come out, prepare area with cophenylcaine and lie patient down. Always have O2 sat monitoring and lie patient down with pillow under shoulders to replace if possible.
Review:
GP if long term trach and no issue, consider if any follow up needed at all ENT clinic as needed.

Blomsinger Valve out –
Blomsinger valve is a white piece of plastic tubing that allows air to go from trachea into oesophagus for speech after laryngeal surgery. The tract is only 5-8mm in size and closes over very quickly. Most patient are aware of the importance of maintaining this tract otherwise a further operation is needed to recreate the pathway if it occludes. Some patients will report leakage when drinking fluids from around the valve when it gets blocked.
Management
Blocked valve still in position – speech path review following day for new valve insertion.
Valve out – immediately spray area with cophenylcaine and then place a nasogastric tube 10-15cm down the tract. This will keep the area open until such time that a new valve can safely be inserted. CALL ENT REG IF YOU CAN’T GET ANYTHING DOWN.
Review:
Speech path and home ENT carer if difficulties, if repositioned then nil further.

Tonsillitis:
Very common in winter and in people that are susceptible. All ages affected.
Exclude respiratory compromise.
Management:
ANALGESIA
Antibiotics- oral vs IV
Penicillin and/or Flagyl
Steroids to decrease swelling Dexamethasone 0.1mg/kg iv BD
IV fluids
Often after all these things and observation for 2 hours then patient is able to cope with going home. If not then consider CDMU admission, paeds admission Swab can be taken to confirm organism.
Review:
GP in a week if first bad attack for consideration of referral to ENT.

Quinsy:
Relatively common condition complication of tonsillitis. Infection between the tonsil and the pharyngeal musculature. Usually have history of sore throat >5 days, partially treated and then got worse. Voice change, trismus, poor oral intake hot potato voice.
Management: Get basic treatment started and call ENT reg to consider drainage

**ANALGESIA**
Antibiotics- oral vs IV
Penicillin and/or Flagyl
Steroids to decrease swelling Dexamethasone 0.1mg/kg iv BD
IV fluids

**Review:**
1st episode in non recurrent tonsillitis – GP review
2nd Quinsy ENT review 4-6 weeks for discussion re tonsillectomy

**Post Tonsillectomy bleeding**
Occurs in up to 5% of patients. Only 1% patient will need to return to theatre. Anytime up to 21days post op. Important to quantitate the amount of blood loss on history in terms of cups or teaspoons
Management:
Any patient with > 10ml blood loss post tonsillectomy should be admitted for observation as increased chance of further bleed. ALL children <10yo
Examine mouth – clot in fossa no bleeding leave alone,
Clot in mouth active bleeding try cauterise bleed points. Silver nitrate.
Cophenylcaine on gauze held by Rampley forceps pushed onto tonsil fossa provides good result and allows direct pressure.
Give patient a sucker this can help them clear blood in mouth and allows you to quantitate ongoing losses.
Active bleeding ongoing losses CALL ENT REG
Ensure IV Access, full set bloods sent, FBE, UEC, Coags, Group and Hold.

**Glandular Fever:**
Common problem in teenagers and young adults. Classically have exudate on tonsils and gross cervical lymphadenopathy. Often difficult to separate from tonsillitis.
Management:
ANALGESIA
Antibiotics- oral vs IV to treat bacterial superinfection if severe.
Penicillin and/or Flagyl
Steroids to decrease swelling Dexamethasone 0.1mg/kg iv BD
**BEWARE THE AIRWAY OBSTRUCTION**
IV fluids
Ensure do full set of bloods FBE, UEC, LFT, CRP and Serology and examine the abdomen and advise re contact sport re spleen and liver.

**Burns – Airway**
This is often related to blast injury or flash burn.
Management:
If airway compromise intubate sooner rather that later as oedema will make delaying management more difficult.
If patient stable but evidence of mild burn airway should be assessed by ENT. Observe overnight 24hours in CDMU.

**Angioedema**
Increasing in prevalence given that so many patient now on ACE inhibitors or ANG II receptor antagonists. Most cases will settle spontaneously but need to be
aware may progress and risk airway compromise. ENT should be alerted regarding patient presence in hospital and potential need for airway management. Management:

Steroids – dexamethasone 0.1mg / kg IV BD
Antihistamine – Phenergan
Adrenaline – nebulised and or IV – consider cardiac function.
Oxygen
Airway assessment ENT
Consider HDU or ICU admission for observation.
DESCRIPTION OF ENT TRAINING - OVERALL

During the five-year SET program, trainees will be expected to become familiar with all aspects of medicine and surgery involving the main subdivisions of the Specialty, namely otology, rhinology, laryngology and head and neck surgery.

In the experience to be obtained, there should be a balance between inpatient and outpatient work, and between adults and children.

Trainees are expected to take progressive responsibility for clinical and operative work during the tenure of SET which is designed to create a broadly based otorhinolaryngologist who is competent to practice the speciality.

The Trainees section of the ASOHNS website is an extremely useful resource and should be visited regularly. (www.asohns.org.au)

The RACS site is also essential.

The Society has now formulated a formal guide to the syllabus in the form of modules. This guide not only gives direction for study but also provides references for suggested reading and journal use.

AIM OF TRAINING AT UNIVERSITY HOSPITAL, GEELONG

At the commencement of your Geelong year, an introductory meeting with the supervisor of Surgical Training will be arranged. At this meeting we will assess your previous medical experience, particular Otolaryngology training, with reference to your logbook and Supervisor reports. An impression of your background and study habits will be reviewed.

Ideally a Learning Contract can be formed focussing on 2 directions:

- What would you like to learn?
- What do we think you should learn?

Goals should be set for medical exposure, surgical experience and acquisition of knowledge.

As a trainee, there will be many new experiences and challenges. The Registrar should make the most of every opportunity but never hesitate to ask if unsure. Patience will be required by both the Registrar and consultants during the early weeks. Study should start from day 1 with a clear plan for the 5 years. It is vital to read-around everything.

Surgical techniques will be taught in a gradual and controlled process. The registrar will be taught based on previous experience and level of technical skill. Many procedures may be taught from scratch but this is appropriate until a level of competency is assessed.

It is hoped that a wide experience will be provided in most components of Otolaryngology, and the trainee should make the most of the available experience. There is a busy paediatric practice, with regular exposure to children both in theatre and clinic. The head and neck subgroup is very active with regular major cases.
At all times, a consultant is on-call for the Geelong Hospital. It is essential that the Registrar should NOT feel out of depth and should not hesitate to call the On-Call if there is a problem. It is much more embarrassing to overstep your ability than to admit that you 'do not know'.

During the year, the trainee will be provided with increasing responsibility, appropriate to the level of experience. Obviously, initially, supervision will be close, both in clinic and in theatre. New patients in the outpatients will be expected to be presented to a consultant. In theatre, the trainee will be provided with cases and involvement appropriately. This will ALWAYS be under supervision of a surgeon, scrubbed or unscrubbed.

Obviously the level of experience obtained will depend on the case load during the year.

It must always be remembered that much can be learned by observing others, and time should be made to be in theatre for as many private lists as possible, including those at the St. John of God Hospital, and Geelong Private Hospital. It is worth making a note of the regular private operating lists.

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POST-GRADUATE EDUCATION
FRIDAY  8.00AM (unless otherwise arranged)

FEBRUARY 5       INTRODUCTORY MEETING [CS] (Week 4)
FEBRUARY 12      TUTE - Audiology [CS]
FEBRUARY 19      RADIOLOGY - GMI   (Week 6)
FEBRUARY 26      TUTE - Tonsils and adenoids [NR] (Week 7) - Path
MARCH 4          MORBIDITY (Week 8)
MARCH 11         TUTE - Facial Nerve Anatomy [RN]
MARCH 18         RADIOLOGY - BMI   (Week 2)
MARCH 25         EASTER
APRIL 1          TUTE - Grommets and eustachian tube dysfunction [KA]
APRIL 8          TUTE - Paediatric Airways Disease [MB]
APRIL 15         RADIOLOGY - Lake Imaging
APRIL 22         TUTE - Temporal Bone anatomy [NR] - Path
APRIL 29         JOURNAL CLUB
MAY 6            TUTE - Rhinitis/Chronic sinusitis [RC]
MAY 13           RADIOLOGY - BMI   (Week 2)
MAY 20           TUTE - Thyroid surgery [NA]
MAY 27           MORBIDITY
JUNE 3           TUTE - Radiotherapy [to be arranged]
JUNE 10          RADIOLOGY - GMI   (Week 6)
JUNE 17          TUTE - Airway obstruction and management [KA]
                 - Path
JUNE 24          RESIDENT PRESENTATION
JULY 1           TUTE - Chronic Ear Disease and its surgery [CS]
JULY 8       RADIOLOGY - BMI   (Week 2)
JULY 15      TUTE - Endoscopic Sinus Surgery [NR]
JULY 22      JOURNAL CLUB
JULY 29      TUTE - Oro and Oropharyngeal carcinoma [TC]
AUGUST 5     RADIOLOGY - Lake Imaging (Week 6)
AUGUST 12    TUTE - Nasal Airway surgery [RC] - Path
AUGUST 19    MORBIDITY
AUGUST 26    TUTE - Oesophageal conditions [RN]
SEPTEMBER 2  RADIOLOGY - BMI   (Week 2)
SEPTEMBER 9  TUTE - Carcinoma of the neck and its management [NA]
SEPTEMBER 16 RESIDENT PRESENTATION
SEPTEMBER 23 TUTE - Laryngeal carcinoma [MB]
SEPTEMBER 30 RADIOLOGY - GMI   (Week 6)
OCTOBER 7    TUTE - Skull Base Anatomy and osteology [TC] - Path
OCTOBER 14   JOURNAL CLUB
OCTOBER 21   TUTE - Head and Neck Reconstruction [NA]
OCTOBER 28   RADIOLOGY - BMI   (Week 2)
NOVEMBER 4   TUTE - Rhinoplasty [CS]
NOVEMBER 11  RESIDENT PRESENTATION
NOVEMBER 18  TUTE - Oral diseases [KA]
NOVEMBER 25  RADIOLOGY - Lake Imaging (Week 6)
DECEMBER 2   Path
DECEMBER 9   JOURNAL CLUB
DECEMBER 16  RADIOLOGY - GMI (NEED TO ARRANGE DATE)
DECEMBER 23  MORBIDITY/FINAL MEETING 2016

TUTORIALS - Fortnightly. Individual tutorial, with variable format. Registrar is required to have read around the topic and provide a knowledgeable contribution to the session. These will provide an introduction to the syllabus and enable your early study to be directed with a purpose. Venue - as arranged with surgeon.

Formal or informal sessions with Plastic Surgeons, Infectious Diseases physicians and Audiologist would be worthwhile.

RADIOLOGY MEETINGS - Please provide interesting cases (films or patient U.R.) to departments in the week prior to session. [David Lun - University Hospital, Peter Carman/Maurice Goodyear - Geelong Medical Imaging, 52494646, Chien Ho - Lake Imaging, 52731200]

CLINICAL MEETINGS - Meeting room, Birdsey Wing 5, book the meeting room by discussing with the secretary situated in the orthopaedic doctors office opposite the level 5 lifts.

MORBIDITY MEETINGS - 2 monthly review of department morbidity and complications, including readmissions and returns-to-theatre. The details should be presented (handout), with a month-by-month analysis, and year-to-date figures, enabling comparison with future years (obtain from previous registrar).
in 2016 the new ENT website has been commenced
www.geelent.com.au password will be given to you on request.
This contains useful information for the running of the unit but
perhaps ore importantly the Databases for the Head and Neck
Meeting, the Consults Audit and the Operating List Audit. It is
the responsibility of the registrars and residents to maintain
the integrity of this audit database and use it for presentation
of the quarterly meetings.

CASE PRESENTATION - Junior staff presentation of interesting case.
The Registrar should be contacted with cases of interest.

JOURNAL CLUB - Allocation of recent publications by Registrar for
discussion.

PATHOLOGY - Clinical School, Kitchener House. Week 7., 8.00,
Friday morning. Notify Dr Michael Robson with cases (up to 10) early
in week. (Fax to audiotypist @ Pathcare 52210326)

These meetings are open to all medical staff involved with the
Department of Otolaryngology, University Hospital.

PATHOLOGY MEETINGS

WEEK 7
Feb 26   April 22
June 17  Aug 12
Oct 7    Dec 2

LOG BOOK
All trainees embarking on SET program must maintain a log book
according to the College standard, utilising MALT. (See ASOHNS
site.)

CONTINUING ASSESSMENT AT UNIVERSITY HOSPITAL,
GEELONG
There will be regular formal assessments with the Supervisor of
Surgical Training. These meetings should occur 3 monthly, with the
mid-year assessment including input from all 5 surgeons. This will
provide an opportunity to clearly advise on strengths and weaknesses
of the trainee, and also to allow the Registrar to report problems that
may have arisen. Discussion will include feedback from many sections
of the hospital staff, opportunity for the registrar to self-assess and for
prospective planning for the remainder of the year. At this time, the
Log Book summary will be examined, including Temporal Bone and
Sinus dissections.
The meeting dates should be scheduled at the commencement of the
year (Discuss with Craig Semple)
TRAINING GUIDELINES
The ASOHNS website has a detailed manual relating to the ORL Training program which should be read and understood. Timelines and requirements are critical and will not be varied.

BOOKS
The most important point is to be able to cover the syllabus in detail, using whatever texts are available. Increasingly, texts and journals are available via the UHG library, RVEEH library and the internet. The UHG library has recently acquired a number of new texts. The ASOHNS Trainee site has text reviews and recommendations also.

The Geelong library staff are very helpful in obtaining Journals and performing library searches. Photocopying is available in library (billed to department).

TEMPORAL BONE DISSECTION
It is expected that during the 5 years of training, the Registrar will have dissected a number of temporal bones (depending on availability) and to have had the exercise reviewed by a supervisor. The Fellowship requirement is 60 documented temporal bone procedures by the first 18 months of training & attendance at at least two temporal bone courses. Prior to commencing formal mastoid surgery, the supervisor must be convinced of the registrar’s understanding of the temporal bone anatomy and the surgical technique and pitfalls. Temporal bones may be acquired through various sources. Further advice can be obtained from senior registrars.

There is a Temporal Bone laboratory at the Royal Victorian Eye and Ear Hospital which should be available for use by all the trainee registrars. (Facilities may vary) The dissection should be performed following a standard dissection manual, e.g. The House Clinic Manual. It is worth documenting the work done on a standard form, as this enables eased of review. The bones should all be kept and preserved until after presenting for the Fellowship examination.

There is a quarterly meeting of the Victorian branch of the Australian Society of Otolaryngology-Head and Neck Surgery, held at the Royal Victorian Eye and Ear Hospital. This commences at 6.00PM, for an hour, and involves presentations by registrars of interesting cases, reviews or clinical research. The Geelong registrar is expected to attend and PRESENT at these meetings as requested. The presentations should be brief (10 minutes), concise and well-prepared.
and should provide an unusual or interesting insight into a common or not-so-common problem.

The AGM of the Society is the single meeting each year where there is gathering of most Australian Otolaryngologists. It is well attended and visited by notable speakers from overseas each year. The registrars, by attending, obtain benefit at different levels depending of the stage of training. It is required to attend at least 3 of these meeting during training.

Each year there is a Registrar’ Symposium, rotating between the States. This is COMPULSORY for all trainees. It is held in the middle of the year between the first and second Fellowship examinations. The meeting lasts 3+ days and involves lectures and talks designed to give a perspective to the prospective Fellow. There is a trial clinical examination for the SET 4-5. This is a wonderful experience for both the candidates and onlookers (who will be candidates in time!). The meeting is also a great chance to develop contacts with surgeons who will become close colleagues and friends over your working career. There is often a practical course held at the same time.

CONCLUSION
We hope that this document is helpful both, now early in your career, and during the remainder of your training. If you have any comments or suggestions, please feel free to discuss them.

Some useful contacts:
- Hospital 4215 0000 or
  - *9 for switch
- Theatre front desk:
  - x51787
- Anaesthetist in charge:
  - x51929
- Waiting list co-ordinator
  - Trent Richards: x51623
- Waiting list manager
  - Linda: x51622
- Theatre manager (if you want to change/add/move list)
  - Shannon Ryan 0438322176
- Birdsey Wing 5- ENT ward:
  - x52160
- Outpatients clinic 1:
  - x51562 fax 42151383
- Dictation service:
  - #85 ID number (get from HIS) 20 for outpat letter 5 to end
- Andrew Love receptionist to add patients for HNM
  - Eleanor Millard: x52746
- Pathologist for pathology meeting:
  - Mike Robson: 5225 1131 email list: mike.robson@sjog.org.au
- Deakin office to book room for pathology meeting
  - X55100