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With much appreciated funding in the form of *The Journal of Laryngology & Otology* Travelling Fellowship, and at the kind invitation of Professor Clarence Sasaki, Chief of Otolaryngology, I visited the Yale otolaryngology department during May and June 2007 (Figure 1).

This report aims to give a flavour of the department and how it functions, and of the experiences I gained there.

Yale Medical Center

Yale Medical Center, New Haven, is the principal teaching hospital of Connecticut and is situated approximately one and a half hours south of New York. The otolaryngology department sees approximately 15 000 out-patients and performs approximately 6500 operations per year. The key consultants and professors in the department are Professors Sasaki, Son, Ross and Leder and Assistant Professors Kveton, Karas, Michaelides, Friedman and Baum, supported by a dedicated team of clinicians, staff and 10 residents.

My experience of the department

On my first day, I met Professor Sasaki as he was presenting patients to the weekly tumour board meeting, akin to the UK head and neck multidisciplinary team meeting. It would be an understatement to say that he was an active man; not only did he run the tumour board meeting, along with Professor Son, but he also managed to fit in two other out-patient clinics and could be found in theatre four days per week!

I was very fortunate to be given a free rein within the department, and took full advantage of the opportunity to observe many aspects of otolaryngological practice at Yale.

A typical day began with patient rounds at 6.45 a.m. Each patient would be presented by the intern or residents to the rounding team, which included professors and otolaryngology residents. All charts and patient reviews had been prepared, from 5.30 a.m. onwards, by the juniors in the otolaryngology team. That made for a very early start. At the end of the round, the Chief Resident, Tom DellaTorre, would assign daily duties to the residents and medical students. Formal rounds occurred six days per week.

Nobody knew what I meant when asking about 'theatre', and I quickly became adept at the American terminology of the 'OR' (operating room). General OR started at 7.30 a.m. with two adult and one paediatric otolaryngology lists.

The 10 residents had an active teaching programme. Each was enrolled on a home study programme of the American Academy of Otolaryngology – Head and Neck Surgery, as well as having half a day of dedicated teaching per week. Hospital-based teaching occurred every Wednesday, and rounds would start at 6.15 a.m. on that day to maximise time. Teaching included resident presentations and input from the departments of pathology, radiology and oral surgery. Dedicated bi-weekly teaching time was also allocated to the temporal bone lab for the drilling of cadaveric temporal bones.

The department was also involved in a nationwide sinus simulator evaluation programme, termed 'ES3'. At present, there are only three simulators in the USA, and their role in sinus training has yet to be defined.

In addition, the department held a weekly clinical radiology meeting.

The consultants and my experience of their practices

Obviously, in a department the size of Yale's, I was not able to closely scrutinise the work of all the consultants and clinicians. However, I hope the following gives a flavour of the work of the department which I did observe.

Professor Sasaki and Professor Son

Professor Sasaki's main interest was head and neck cancer and his unit was very busy. During my visit, I saw a range of procedures, including a Le Fort I approach to an extensive angiofibroma. The department had extensive experience of the use of radioactive seed implants for tongue base and tonsil tumours, on which Professor Sasaki worked closely with Professor Son, Chief of Clinical Radiotherapy. Their commitment and drive for excellence was patent.

Professor Ross

Professor Ross was a key member of the head and neck team, with microvascular reconstructive skills and also an extensive interest in nasal pathology. The use of image guidance for sinus surgery was standard practice for him. It was very easy to set up the system and to register the equipment, and overall I was extremely impressed by the technology. While it was no substitute for anatomical knowledge,

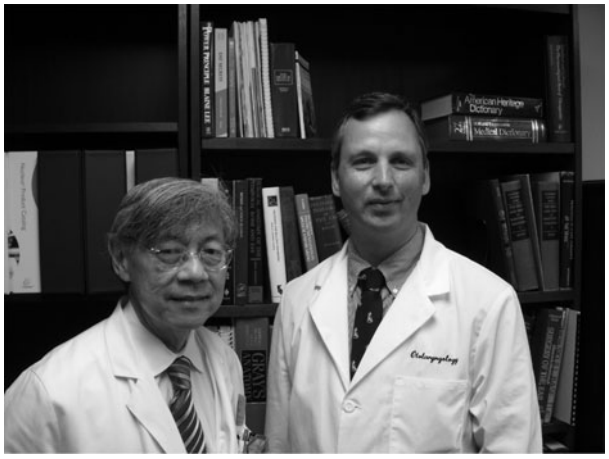

FIG. 1
Professor Clarence Sasaki and Mr Paul Nix.

FIG. 2
Dr Tomas Toukoudes with a transnasal oesophagoscope.

the system in particular allowed the operator to move quickly through the posterior ethmoid cells and to approach the frontal sinus. Professor Ross was also part of the hereditary telangectasia group at Yale. With over 2000 patients registered with the Yale clinic, I observed many procedures on hereditary telangectasia patients. It was fascinating to see the charismatic Professor Ross at work, using a combination of yttrium aluminium garnet (YAG) laser and bipolar diathermy. For patients at the severe end of the spectrum who were transfusion-dependent, he would perform septodermoplasty. This certainly appeared to be an effective and beneficial procedure, from my conversations with the patients.

Dr Karas and Dr Baum

Yale's active paediatric otolaryngology department was run principally by Dr Karas and Dr Baum. I was fortunate to observe paediatric tracheostomies, bronchoscopies and laryngotracheal reconstructions for subglottic stenosis. The department also managed a significant number of parapharyngeal abscesses (approximately two per month). Children who required surgery would be drained per orally as long as the abscess was medial to the great vessels.

Private otolaryngology offices

During my visit, I also had the opportunity to visit private otolaryngology offices run by Drs Kveton and Toukoudes. The offices were situated in the penthouse suite of an office block, with panoramic views of New Haven and a large veranda for lunch time breaks. The otolaryngology equipment in this private office was extremely impressive, including a transnasal oesophagoscope (Figure 2), extensive audiology and vestibular equipment, and even an in-house cochlear implant team.

Patients stepped out of a lift into an elegant waiting area, before being shown to one of three clinic rooms. This facilitated a fast and efficient throughput of patients. I was particularly interested in the transnasal oesophagoscopies regularly performed by Dr Toukoudes. The procedure was tolerated very well by the patient and recorded onto a K system for later, detailed viewing. At the time of my visit, Dr Toukoudes was using this only as a screening process. The practice also had facilities to perform out-patient laryngeal and pharyngeal biopsies, using a side port on a flexible nasal endoscope. Lunchtime was a welcome break from the busy private office schedule, and included my first American hot dog. This was cooked on the outside barbecue while I enjoyed the heat haze view of downtown New Haven.

Leisure time

When time permitted during my Fellowship, I explored the city of New Haven, dominated by the Ivy League campus of Yale University. The campus was modelled after Oxbridge and certainly reproduced the spectacular architecture of Oxford. I was also privileged to be invited to Mory's, a Yale alumni club and past haunt of a number of American presidents (Figure 3).

FIG. 3
Mr Paul Nix and Professor Doug Ross at Mory's, the Yale alumni club.

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At weekends, I took the opportunity to visit the surrounding area, including the magnificent sights of Boston and New York. Inevitably, I have a host of touristy photos with spectacular views from the Empire State Building, New York Metropolitan Museum . . . and even of afternoon tea at the Waldorf Astoria!

Acknowledgements

My visit to Yale has afforded me great educational benefit, enabling me to observe North American otolaryngology practice, to reflect on similarities and disparities with UK practice, and to experience the residents' training scheme.

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