



Appendix 1: Otolaryngology - head and neck surgery Procedure Minimum Numbers

This list is intended to be used in conjunction with the **Procedure Log Guidelines for Residency and Fellowship Programs** to ensure comprehensive documentation and compliance with training requirements.

Minimum numbers represent what the Central Accreditation Committee believes to be an acceptable minimal experience. Minimum numbers are not a final target number and achievement of the minimum does not signify competence.

Category	Minimum
Head and Neck	
Parotidectomy (all types)	15
Neck dissection (all types)	27
Oral Cavity resection	10
Thyroid/Parathyroidectomy	22
Otology/Audiology	
Tympanoplasty (all types)	17
Mastoidectomy (all types)	15
Stapedectomy/ossiculoplasty	10
FPRS	
Rhinoplasty (all types)	8
Mandible/Midface Fractures	12
Flaps and Grafts	20
General/Pediatrics	
Airway – Pediatric and Adult	20
Congenital Neck Masses	7
Ethmoidectomy	40
Bronchoscopy	22
Total number of procedures	



Resident Roles

When residents enter a case into the NIHS Procedure Log System, they must indicate their major role in the case (autonomy level).

- **Assistant** scrubbed in and performed less than 50 percent of the procedure or greater than or equal to 50 percent, but not the key portion(s) of the procedure.
- **Independent** must perform greater than or equal to 50 percent of the procedure, including the key portion(s) of the procedure. This is consistent with level 4 on the EPA entrustment scale.
- **Teaching Assistant** This is consistent with level 5 on the EPA entrustment scale. To be recorded as Teaching Assistant in the Procedure Log System, an entrusted resident must instruct and assist a more junior resident through a procedure. The more junior resident must function as Surgeon and perform greater than or equal to 50 percent of the procedure, including the key portions. The attending/faculty member must function as Assistant or Observer.

Notes

- The roles of Independent Surgeon and Teaching Assistant are given credit toward the required minimum procedural counts.
- No more than two residents may receive credit towards the minimum requirements for a single procedure. When the role criteria outlined above are met, one resident may receive credit as Independent Surgeon and another as Teaching Assistant or two residents may receive credit as Independent Surgeon.
- Procedures performed by residents in the roles of **Independent Surgeon** and **Teaching Assistant** count towards the minimum Case Log requirements. The Central Accreditation Committee, however, emphasizes the importance of the **Assistant Surgeon** role as the individual resident's Case Log data must demonstrate progressive participation and responsibility.



Specific requirements

Logging **otolaryngology - head and neck surgery** surgeries can be challenging because many cases include more than one procedure. To ensure proper credit is given for each case towards the required minimums, residents must ensure the correct procedures are chosen.

- In cases where more than one procedure is performed in a single case, **residents should log each procedure separately**. Avoid definitions that “bundle” several otolaryngology - head and neck surgery procedures.

For example, a case involving a tympanoplasty with mastoidectomy and ossicular chain reconstruction should be logged as three separate procedures. A cochlear implant should be logged as a mastoidectomy and a CI.

- Case Logs should reflect the hard work a resident has done in the program. Residents should take credit for what they have performed and log cases appropriately. When documenting, pay special attention to laser, robotic, sialendoscopy, and ultrasound experience, as these categories of procedures often require additional documentation when applying for privileges.

- Other **than the three Ts (turbينات, tonsils, and tubes), which are considered per patient, all other cases are to be logged per side**.

For example, performing a bilateral neck dissection results in credit for two neck dissections.

For a total thyroidectomy, if the resident is the independent surgeon for the entire case, it should be coded as one total thyroid. If the resident is the assistant surgeon for one side and the resident surgeon for the other side, the case should be coded as two thyroid lobectomies, once under resident surgeon and once under assistant surgeon.

- In some cases, bilaterality or sequences of procedures must be registered and logged separately **to capture correctly the operative experiences**.

The most notable example is the central compartment neck dissection. If the procedure is done bilaterally this should be logged twice.

Surgeries that include the excision of a lesion and a specific reconstruction must be recorded as 2 procedures to capture both the excision and the reconstructive procedure (e.g., rotational flap).



cases Surgeries that contain the primary extirpative procedure and a neck dissection should be logged once with the appropriate description for the resection and again as a separate neck dissection.

- **Ossicular chain reconstruction must be logged separate from** tympanoplasty.
- **There four areas of patient management that help capture the non-surgical aspects of otolaryngology - head and neck surgery:**
 - **Infant with stridor;**
 - **Infant with hearing loss;**
 - **Complications of sinusitis;**
 - **Complications of otitis media.**

It is mandatory for a resident to log participation in the care of patients with these diseases to demonstrate the resident's exposure to them. These experiences only need to be coded once per patient even if the resident sees the same patient multiple times throughout the course of the disease process.

Frequently Asked Questions

Q. Does a pediatric laryngotracheal examination with a laryngoscope and a telescope count as a bronchoscopy Case?

No, such an examination does not count as a bronchoscopy case because there is no utilization of a bronchoscope, and the entire lower airway is typically not examined.

Q. In a total thyroidectomy, if the parathyroid is explored or examined but not removed, can this procedure be counted as a parathyroidectomy in the Case Log System?

No. Parathyroid glands are commonly seen during a thyroidectomy, but the parathyroidectomy procedure assumes a proper parathyroid workup has been accomplished pre-operatively, and that the surgical approach is primarily for parathyroid removal. Unless this evaluation is performed, the parathyroidectomy code should not be used.



Q. Can surgical procedures done on non-otolaryngology - head and neck surgery rotations in other NIHS-accredited programs be entered in the resident's otolaryngology Case Logs?

A resident can choose to keep a record of all procedures, but for the purposes of the Central Accreditation Committee, only the otolaryngology - head and neck surgery procedures should be entered into the Case Log System.

Q. Can operative procedures done during an international rotation be counted toward Case Log minimums?

Yes, if logging rules are applied.

Q. How should residents report for procedures that include several major components, such as laryngopharyngectomy with bilateral neck dissection, in the Case Log System?

Residents should use the description for laryngopharyngectomy to reflect the extirpative procedure and enter each neck dissection side separately.

An additional entry would be needed to capture the reconstruction. Yet another entry would be used if an additional reconstructive procedure were used on the donor site (as in the case of closing a forearm donor site with a skin graft). Therefore, a patient undergoing such a complex operation would require entering at least five procedures (one for the primary resection, two for the bilateral neck dissection, one for the free flap, and one for the graft to close the donor site).

Q. Why must all residents in a program have essentially equivalent distributions of case categories and procedures?

The Central Accreditation Committee expects that residents' educational experience should be fairly equivalent within a program so that all graduates have sufficient volume and variety of educational experiences to prepare them for independent practice as a general otolaryngologist. The Committee sees a significant parity issue if one resident has had insufficient experience in a particular clinical area, while the other residents in the program have had an excess experience. Generally, disparities in case numbers between graduating residents



are not seen as significant if there are no areas of clinical deficiency (i.e., all procedure minimums are met).

Q. What are the Central Accreditation Committee's expectations for entering operative procedures into the Case Log System?

Residents must use the definitions provided for assistant surgeon, resident independent surgeon, and resident supervisor to accurately describe their participation in the case. Residents should discuss with the attending surgeon at the end of the case how to correctly identify themselves if there is any doubt as to the level of participation.

- **Assistant Surgeon:** An assistant surgeon performs less than 50 percent of the procedure, or greater than or equal to 50 percent, but not the key portion(s) of the procedure. *To claim a procedure, a resident must "scrub in." Being present in the room as an observer does not count as having served as an assistant surgeon.*
- **Independent Surgeon:** A resident independent surgeon performs greater than or equal to 50 percent of the procedure, including the key portion(s) of the procedure, with the attending surgeon and/or resident supervisor (if applicable).
- **Teaching Assistant:** A resident supervisor instructs and assists a more junior resident through a procedure during which the junior resident performs greater than or equal to 50 percent of the procedure including the key portion(s). The attending surgeon functions as an assistant or observer in such circumstances.

Some cases have multiple procedures, each allowing for different levels of resident participation. Each resident may claim only one role per procedure (i.e., one cannot be both the teaching surgeon and the independent surgeon for a specific portion of the case). Two residents cannot claim the same role for any specific procedure other than assistant surgeon.

Example 1: Two residents scrub in with an attending on a parotidectomy with neck dissection.



Resident A performs more than 50 percent of the key portions of the parotidectomy while Resident B assists. The residents switch roles for the neck dissection procedure, with Resident B performing less than 50 percent of the procedure and the key portions.

In this case:

- Resident A will register as **Independent Surgeon** for the parotidectomy and **Assistant Surgeon** for the neck dissection;
- Resident B will register as **Assistant Surgeon** for the parotidectomy and **Independent Surgeon** for the neck dissection.
- If the attending surgeon allows Resident A to serve a supervisory role for Resident B on the neck dissection, then Resident A should report the Neck Dissection as **Teaching Assistant**.

Example 2: Two residents scrub in on an endoscopic sinus surgical case involving bilateral total ethmoidectomies and sphenoidotomies.

Resident A performs the procedures on the right side while Resident B assists and observes. Resident B performs the procedures on the left side with Resident A supervising.

In this case:

- Resident A would register a total ethmoidectomy and sphenoidotomy as a **Independent Surgeon** for the right sided procedures, and a total ethmoidectomy and sphenoidotomy as a **Teaching Assistant** for the left sided procedures.
- Resident B would register a total ethmoidectomy and sphenoidotomy as a **Assistant Surgeon** for the right sided procedures, and a total ethmoidectomy and sphenoidotomy as a **Independent Surgeon** for the left sided procedures.

Program directors must monitor the timely entry and accuracy of their residents' procedures in the Case Log System. Cumulative procedure numbers should be reviewed with each resident at least on a semiannual basis as part of the resident assessment process with respect to the development of each resident's surgical skills.



Q. How should the program document progressive resident performance improvement and improvement toward unsupervised practice?

Residents should be formatively evaluated based upon the progressive educational expectations delineated in the program's goals and objectives. In terms of the program's progressive operative education, all residents must have the opportunity to start as an "assistant" before becoming the "independent surgeon" for procedures. Some residents may take longer than others to progress to the "independent surgeon" level.

Q. How should residents' Case Logs be monitored?

Programs must monitor the accurate and timely entry of cases into the system. As part of monitoring resident progress towards developing competence in surgical skills, cumulative operative experience reports should be reviewed with each resident at a minimum as part of the semiannual review. More frequent monitoring and feedback is highly recommended.