1 Patient Information

1 PATIENT DETAILS

Name
Brendan T. Calloway

Date of Service
05/06/2026

DOB
08/04/1981

Provider
Dr. Vanessa L. Kim, MD — Otolaryngology / Head & Neck Surgery

Age / Sex
44 / Male

MRN
ENT-2026-0441

Referring Provider
Dr. Alan Park, MD — Internal Medicine

Visit Type
Initial ENT / Otolaryngology Consultation

Reason for Referral
Right neck mass x6 weeks, progressive hoarseness, dysphagia, 14 lb weight loss

CC Chief Complaint

2 PRIMARY ENT CONCERN

Patient presents with a 6-week history of a painless, enlarging right-sided neck mass, progressive hoarseness beginning approximately 8 weeks ago, and increasing difficulty swallowing solid foods over the past 3 weeks. He states: 'I noticed a lump on the right side of my neck that keeps getting bigger and my voice has been getting raspy — my wife says I sound different. I've lost a lot of weight because eating is getting hard.' He has been an active smoker (35 pack-years) and reports a history of multiple sexual partners with known HPV exposure in his 20s.

S Subjective

3 PATIENT-REPORTED SYMPTOMS, REFERRAL CONTEXT & ENT HISTORY

3a SYMPTOM ONSET & COURSE

Right neck mass first noticed approximately 6 weeks ago (late March 2026) — described as a 'firm lump on the right side of the neck below the jaw.' It has progressively enlarged over this period and is now visibly prominent. Hoarseness onset was approximately 8 weeks ago (mid-March 2026) — initially intermittent, now constant. Progressive dysphagia began approximately 3 weeks ago — initially solids only, now having difficulty with dense foods. 14 lb unintentional weight loss over approximately 6 weeks. He attributed his symptoms to 'a bad throat infection' and delayed seeking care. He was seen by Dr. Park last week who performed a neck exam, palpated the mass at approximately 3 cm, and referred him urgently.

3b ANATOMICAL LOCATION & LATERALITY

RIGHT-SIDED: Right level II/III cervical lymphadenopathy — palpable single firm mass at right submandibular/upper jugular region, approximately 3 cm per patient's report. Right-sided throat discomfort. Hoarseness without clear laterality by patient perception — noted on laryngoscopy as right vocal cord paresis today. No left-sided mass. No bilateral involvement by patient report. No midline neck concern.

3c EAR SYMPTOMS

Right-sided otalgia — intermittent, moderate (4/10) — referred otalgia from oropharyngeal region is a classic symptom of oropharyngeal malignancy. No hearing loss, tinnitus, otorrhea, or aural fullness. No history of ear infections or ear surgery. No noise exposure concerns.

3d NASAL / SINUS SYMPTOMS

Mild bilateral nasal congestion — chronic, attributed to allergies. No epistaxis, facial pressure, or anosmia. No sinus infections reported. No prior sinus surgery.

3e THROAT / VOICE / SWALLOWING SYMPTOMS

Hoarseness — constant, 8-week duration, progressive. Dysphagia — progressive, solid foods primarily; now having difficulty with dense proteins and bread. Mild odynophagia on the right side with large swallows. Globus sensation — persistent, right-sided. Right-sided throat discomfort (5/10). No aspiration episodes reported, though he is occasionally coughing after eating in the past week. No sore throat per se — more of a persistent right-sided throat tightness. No airway compromise or stridor.

3f HEAD & NECK SYMPTOMS

Right neck mass — progressively enlarging x6 weeks, firm, painless. 14 lb unintentional weight loss over 6 weeks (significant). Moderate fatigue. No fevers or drenching night sweats. No left-sided neck mass. No bilateral lymphadenopathy reported by patient. No salivary gland swelling. No oral lesions noticed by patient. No hemoptysis. Intermittent right-sided otalgia (referred, as above).

3g PRIOR EVALUATION & TREATMENT

No prior ENT evaluation. No prior head/neck imaging. PCP visit last week (first medical contact for these symptoms) — neck mass palpated, urgent ENT referral placed. No prior antibiotics, steroids, or ENT workup for this episode. No prior head or neck surgery. No radiation history. No prior cancer diagnosis. Social history: 35 pack-year smoking history (started age 16, currently 1.5 PPD); alcohol 3–4 drinks/week; history of multiple sexual partners, known HPV exposure — never vaccinated for HPV.

3h PERTINENT NEGATIVES

Denies sudden hearing loss, severe vertigo, or neurologic deficits. Denies complete airway compromise or stridor. Denies hemoptysis (has coughed with meals occasionally — see above). Denies fever. Denies trismus (mouth opens fully). Denies facial weakness or facial numbness. Denies chest pain or dyspnea at rest. Denies supraclavicular masses by palpation. Denies prior malignancy. Denies immunosuppression.

ROS ENT Review of Systems

4 PERTINENT POSITIVES & NEGATIVES

- **Hearing loss / tinnitus / otorrhea:** Denied
- **Dizziness / vertigo:** Denied
- **Facial pain / pressure:** Denied
- **Sore throat / dysphagia:** POSITIVE — dysphagia solids, right throat discomfort
- **Hoarseness / voice change:** POSITIVE — constant, 8 weeks, progressive
- **Neck mass:** POSITIVE — right level II/III, firm, progressive, 6 weeks
- **Fever / weight loss / night sweats:** 14 lb weight loss; no fever; fatigue present
- **Otalgia:** POSITIVE — right-sided, intermittent referred otalgia
- **Nasal obstruction / rhinorrhea:** Mild chronic congestion — not new
- **Smell disturbance:** Denied
- **Odynophagia:** Mild right-sided with large swallows
- **Chronic cough:** New coughing with meals x1 week
- **Thyroid / salivary swelling:** Denied

O Objective

5 MEASURABLE & OBSERVED FINDINGS

V VITAL SIGNS

Temperature
98.3°F

Blood Pressure
132/80 mmHg

Heart Rate
78 bpm

Respiratory Rate
14 breaths/min

Oxygen Saturation
98% on room air

Height / Weight
5'10" / 174 lbs (BMI 24.9) — down 14 lbs from 188 lbs 6 weeks ago per PCP records

Pain Score
3/10 right throat discomfort at rest; 5/10 with swallowing

5a GENERAL APPEARANCE

Alert, well-appearing male in no acute distress. Mildly hoarse voice — audible from across the room. Slightly thin appearance consistent with recent weight loss. Breathing comfortably with no stridor. Cooperative throughout examination.

5b HEAD & FACE / EYES

Head & Face

Normocephalic, atraumatic. Facial symmetry intact. No facial swelling or masses. No facial nerve weakness — symmetric smile, brow raise, eye closure. No tenderness.

Eyes

EOMs intact. No nystagmus. Conjunctivae clear, sclerae non-icteric. No periorbital edema.

5c EAR EXAM

RIGHT EAR: External ear intact. Canal clear. Tympanic membrane: intact, normal landmarks, no effusion, no erythema — however right TM slightly retracted, mildly reduced mobility (consistent with Eustachian tube dysfunction from right oropharyngeal mass effect or referred congestion). LEFT EAR: Normal TM, patent canal. No mastoid tenderness bilaterally.

5d NASAL EXAM

External nose: normal. Bilateral inferior turbinate hypertrophy — mild, consistent with chronic allergic rhinitis. Nasal mucosa mildly erythematous and edematous bilaterally. Septum: mild left deviation, not obstructive. No masses, polyps, or discrete lesions. Mild bilateral clear discharge. Anterior rhinoscopy visualization adequate without obstruction of the nasal vault.

5e ORAL CAVITY / OROPHARYNX

Lips, oral mucosa, teeth, and floor of mouth: unremarkable. Tongue: protrudes midline, no fasciculations, no lesions. SOFT PALATE / OROPHARYNX: RIGHT POSTERIOR PHARYNGEAL WALL and RIGHT BASE OF TONGUE: Asymmetric fullness and subtle submucosal bulging of the right base of tongue/right pharyngeal wall region — visible on indirect mirror exam and confirmed on flexible laryngoscopy. Mucosa overlying the area appears intact but there is clear submucosal mass effect. RIGHT TONSIL: Mildly asymmetrically enlarged compared to left (grade 2+ vs grade 1+). No frank exudate. No ulceration. Uvula: midline. Posterior pharyngeal wall: irregular cobblestoning — likely chronic LPR/rhinitis.

5f NECK — PRIMARY FINDING

RIGHT LEVEL II/III: Single, firm, non-tender, rubbery-to-hard lymph node at the right upper jugular region (level II), approximately 3.2 x 2.8 cm on careful bimanual palpation. Overlying skin: non-erythematous, no fluctuance, no skin tethering. The node is mobile but not freely mobile — slight resistance to lateral displacement. RIGHT LEVEL III: An additional smaller firm node at level III, approximately 1.4 cm, also palpable. No bilateral cervical adenopathy. Trachea: midline. Thyroid: not enlarged, no nodules palpable. Carotid pulses: 2+ bilateral. No bruit. Salivary glands: bilateral parotid and submandibular glands normal to palpation.

5g RESPIRATORY / AIRWAY & NEUROLOGICAL

Respiratory / Airway

Unlabored breathing. No stridor. No accessory muscle use. Voice hoarse but phonates. Airway not compromised.

Cranial Nerves

CN V: facial sensation intact bilaterally. CN VII: symmetric. CN IX/X: gag reflex present bilaterally; palate elevation symmetric. CN XI: shoulder shrug 5/5 bilateral. CN XII: tongue midline, no fasciculations.

PP Procedures Performed

6 ENT PROCEDURES THIS VISIT

FLEXIBLE LARYNGOSCOPY WITH DISTAL CHIP CAMERA (performed today by Dr. Kim): Indication: progressive hoarseness, dysphagia, right neck mass, and right oropharyngeal asymmetry. Technique: 4% lidocaine topical nasal anesthesia with oxymetazoline decongestant applied bilateral nares. Olympus ENF-VH scope introduced through the right nasal passage. Findings: (1) NASOPHARYNX: No masses or asymmetry. Eustachian tube orifices patent bilaterally. (2) BASE OF TONGUE / RIGHT OROPHARYNX: Asymmetric fullness and submucosal bulging at the right base of tongue, extending into the right oropharyngeal wall. No frank ulceration; mucosa intact but irregular and thickened on the right. Left base of tongue and oropharynx normal. (3) HYPOPHARYNX: Pooling of secretions in the right piriform sinus — consistent with right-sided pharyngeal weakness from recurrent laryngeal nerve involvement. (4) LARYNX: RIGHT VOCAL CORD PARESIS — the right true vocal cord is incompletely mobile, failing to reach midline on attempted phonation. Left true vocal cord: fully mobile. False cords: symmetric. Epiglottis: normal. Arytenoids: right arytenoid sluggish — consistent with right RLN paresis or direct tumor involvement. No supraglottic or glottic masses. Subglottic: not well visualized. Patient tolerated procedure without significant discomfort. No adverse events.

L Lab & Diagnostic Results

7 REVIEWED DATA

7a AUDIOLOGY

No audiogram performed today — not the primary presenting concern. May be ordered if middle ear effusion confirmed on follow-up exam (right TM retraction noted).

7b IMAGING

No prior imaging available. ORDERED TODAY (URGENT): (1) CT neck with contrast (soft tissue windows): evaluate primary oropharyngeal mass, right cervical adenopathy extent, vascular encasement, and retropharyngeal involvement. (2) CT chest with contrast: staging — assess for pulmonary metastases or synchronous primary. (3) PET/CT (scheduled via oncology coordination): systemic staging. All imaging ordered STAT; scheduling with radiology initiated today. MRI oropharynx/neck with contrast to follow pending biopsy confirmation.

7c LABORATORY STUDIES

CBC, CMP, TSH, LDH ordered today — baseline pre-treatment evaluation. HIV test ordered (relevant to immune function and squamous cell pathogenesis). p16 IHC will be performed on biopsy specimen. No prior labs available from PCP except basic CMP (normal) and CBC (WBC 8.4, Hgb 13.2 — mild anemia consistent with nutritional impact).

7d PATHOLOGY / CYTOLOGY

No prior biopsy or pathology. PLANNED: Ultrasound-guided FNA of right level II cervical node — to be performed tomorrow (05/07/2026) by interventional radiology (Dr. Chen). FNA to be sent for cytology, p16 IHC, and cell block. If FNA inconclusive: core needle biopsy or open biopsy will follow. Panendoscopy (direct laryngoscopy, esophagoscopy, bronchoscopy) under general anesthesia to be scheduled for biopsy of the right base of tongue primary suspect site once imaging is completed — tentatively 05/12/2026.

A Assessment

8 ENT CLINICAL INTERPRETATION

Mr. Brendan Calloway is a 44-year-old male heavy smoker and HPV-exposure-history patient presenting with a high-suspicion constellation of findings for SQUAMOUS CELL CARCINOMA OF THE RIGHT OROPHARYNX (base of tongue/oropharyngeal wall primary) with cervical lymph node metastases, based on: (1) Right base of tongue submucosal mass effect on flexible laryngoscopy; (2) Firm, 3.2 cm right level II cervical lymphadenopathy + secondary 1.4 cm level III node; (3) Right vocal cord paresis (right RLN involvement — either direct tumor extension to the RLN course or parapharyngeal/carotid space involvement by metastatic node); (4) Referred right otalgia (classic for oropharyngeal malignancy via Jacobson's nerve/Arnold's nerve); (5) Progressive dysphagia and 14 lb weight loss; (6) Significant tobacco history (35 pack-years) and HPV exposure history. Probable staging at presentation: T2–T3, N2b–N2c, M0 (preliminary — final staging pending CT, PET/CT, and pathology). Right vocal cord paresis raises concern for T4 disease or N2 disease with extranodal extension — critical to clarify on imaging. Differential: lymphoma (less likely given clinical picture), EBV-related nasopharyngeal carcinoma (no nasopharyngeal mass on scope), branchial cleft cyst (age and bilateral nature makes this highly unlikely). Urgency: HIGH — requires expedited staging workup and multidisciplinary tumor board review.

P Plan

9 ENT MANAGEMENT

9a MEDICATIONS

Ibuprofen 400 mg PO TID with food for pain management. Omeprazole 20 mg PO daily for LPR/GERD (cobblestoning noted). Magic mouthwash PRN for oral discomfort. Nutritional supplement: Ensure High Protein 2 cans/day — patient counseled on maintaining caloric intake during workup. No steroids at this time (may obscure pathology). Tobacco cessation: counseled strongly — varenicline 1 mg BID discussed; patient receptive to initiating.

9b DIAGNOSTIC TESTING ORDERED

CT neck with contrast — STAT, 05/07/2026. CT chest with contrast — STAT, 05/07/2026. PET/CT — ordered urgently, coordination with medical oncology for expedited scheduling. Ultrasound-guided FNA right level II node — 05/07/2026 (IR). Panendoscopy + base of tongue biopsy — tentatively 05/12/2026 OR. CBC, CMP, TSH, LDH, HIV — ordered today. MRI oropharynx/neck — to follow pending biopsy confirmation.

9c SURGICAL DISCUSSION

Panendoscopy under GA for primary site biopsy is the definitive diagnostic procedure — this will also assess the extent of oropharyngeal involvement, bilateral submucosal spread, and synchronous primaries. Surgical resection will depend on final staging; transoral robotic surgery (TORS) may be an option for select oropharyngeal primaries. Neck dissection will be discussed at MDT. Tracheotomy is not anticipated at this time (airway not compromised). Surgical consent and risks/benefits/alternatives discussion to occur at the pre-operative visit after staging is complete.

9d PATIENT EDUCATION & REFERRALS

Patient and wife counseled on today's findings — explained clearly that the examination findings are highly concerning for a throat cancer and that urgent testing over the next 1–2 weeks will determine the diagnosis and treatment plan. Multidisciplinary tumor board (head and neck oncology, radiation oncology, medical oncology, radiology, pathology, speech therapy, nutrition) referral placed for 05/14/2026. Medical oncology referral placed (Dr. Lisa Park, MD). Radiation oncology referral placed (Dr. David Cho, MD). Speech therapy and nutrition referrals placed. Tobacco cessation counseling provided; varenicline prescription written. Patient was advised strongly NOT to delay any of the scheduled procedures. Warning signs requiring ER: severe dysphagia with inability to manage saliva, airway compromise, stridor, or heavy bleeding.

F Follow-Up

10 REASSESSMENT PLAN

Follow-Up Schedule

FNA: 05/07/2026. CT imaging review + FNA results: 05/09/2026 (telephone). Panendoscopy: 05/12/2026. MDT tumor board: 05/14/2026. ENT clinic follow-up: 05/14/2026 post-MDT — staging, pathology, and treatment plan discussion.

TIME DOCUMENTATION & BILLING

Total Time

55 minutes

E/M Level

99205 — New patient, high complexity

Counseling / Coordination Time

20 minutes

Procedure Code(s)

31505 — Laryngoscopy, indirect, with biopsy; 31575 — Flexible laryngoscopy

Basis for Billing

Medical Decision Making — High Complexity

Primary ICD-10 Code

C10.9 — Malignant neoplasm of oropharynx, unspecified (suspected — pending biopsy)

Secondary ICD-10 Code(s)

C77.0 — Secondary malignant neoplasm, cervical nodes; J38.01 — Paralysis of vocal cords, right; R13.10 — Dysphagia

PHYSICIAN NAME, MD	SPECIALTY	DATE	TIME
Vanessa L. Kim, MD	MD — Otolaryngology / Head & Neck Surgery | Board Certified (ABOto)	05/06/2026, 9:15 AM	