

**1 Patient Information****1 PATIENT DETAILS**

<b>Name</b> Margaret E. Holloway	<b>Date of Service</b> 05/06/2026
<b>DOB</b> 11/14/1967	<b>Provider</b> Dr. Jonathan S. Reid, MD — Otolaryngology / Rhinology
<b>Age / Sex</b> 58 / Female	<b>MRN</b> ENT-2025-1881
<b>Visit Type</b> ENT / Otolaryngology Follow-Up — 3-Month Post-FESS	<b>Reason for Follow-Up</b> Post-operative evaluation, nasal polyp surveillance, and biologic therapy candidacy assessment
<b>Prior Diagnosis / Condition</b> Chronic rhinosinusitis with nasal polyposis (CRSwNP), eosinophilic, comorbid asthma	

**CC Chief Complaint****2 PRIMARY FOLLOW-UP CONCERN**

Patient presents for 3-month post-operative follow-up after bilateral functional endoscopic sinus surgery (FESS) with bilateral total ethmoidectomy, bilateral maxillary antrostomy, bilateral sphenoidotomy, bilateral Draf IIa frontal sinusotomy, and bilateral nasal polypectomy performed 02/04/2026 by Dr. Reid. She reports significant improvement in nasal congestion and facial pressure but persistent complete anosmia and early signs of polyp recurrence noticed by her since last month. She states: 'My breathing is so much better and the pressure headaches are gone — but I still can't smell anything and I think I feel something growing back in my nose. I'm worried about needing another surgery.'

**S Subjective****3 INTERVAL HISTORY & PATIENT-REPORTED RESPONSE SINCE PRIOR VISIT****3a INTERVAL CHANGES**

Overall: Significant improvement in nasal breathing (subjective 8/10 vs. 2/10 pre-op), resolution of facial pressure and headaches. Post-operative recovery was uncomplicated — no epistaxis, no infection, no CSF leak. Completed standard post-operative saline irrigations and mometasone spray regimen. However, two new concerns have emerged over the past 4-6 weeks: (1) Complete anosmia has not improved — no subjective smell recovery at all since surgery; (2) Early subjective sense of left-sided nasal blockage and pressure returning over past 4 weeks.

**3b CURRENT ENT SYMPTOMS**

NASAL: Mild bilateral nasal congestion, left > right. No anterior rhinorrhea. Mild postnasal drip. No epistaxis. Persistent complete anosmia — she rates her smell as 0/10 both pre- and post-operatively (no improvement). Early return of left-sided nasal fullness. SINUS: No facial pressure or pain — a marked improvement from pre-operative status. No headaches. THROAT/VOICE: Mild throat clearing from postnasal drip. No hoarseness or dysphagia. ASTHMA: Moderate persistent asthma — currently on fluticasone/salmeterol (Advair 250/50 mcg BID) + montelukast 10 mg daily + albuterol PRN (using 2-3x/week — suboptimal control). She reports mild exertional wheeze. Her pulmonologist (Dr. Sarah Chen) last evaluated her 6 weeks ago — asthma not well-controlled.

**3c TREATMENT RESPONSE**

Post-operative regimen adherence: excellent. Saline irrigations (NeilMed, 240 mL BID): compliant — performing daily. Mometasone nasal spray 200 mcg BID: compliant. Completed post-operative oral prednisone taper (40 mg x5 days, 30 mg x5 days, 20 mg x5 days, 10 mg x5 days) — completed 03/20/2026. During steroid taper: asthma significantly improved; nasal symptoms improved further temporarily. After taper completion: congestion and early left polyp recurrence sensation returned.

### 3d MEDICATION / TREATMENT ADHERENCE

Compliant with: Mometasone 200 mcg BID nasal (confirmed correct technique — head-down sniffing position, angling laterally). Saline irrigations BID. Advair 250/50 BID. Montelukast daily. Albuterol PRN. Aspirin desensitization (AERD protocol) — NOT yet initiated. NSAID avoidance maintained — no NSAID use since surgery (consistent with AERD/Samter triad management). No alcohol or NSAIDs since surgery.

### 3e PROCEDURES / SURGERY SINCE LAST VISIT

No interval procedures. Previous surgery: Bilateral FESS (02/04/2026) — total ethmoidectomy, maxillary antrostomy, sphenoidotomy, Draf IIa frontal sinusotomy, bilateral nasal polypectomy. Pathology (02/2026): Bilateral nasal polyps — eosinophilic chronic rhinosinusitis with nasal polyposis; eosinophil count 52/HPF (markedly elevated); Charcot-Leyden crystals present; no malignancy, no fungal organisms, no evidence of inverted papilloma.

### 3f FUNCTIONAL IMPACT

Nasal breathing: greatly improved — can breathe through nose comfortably at rest; mild exercise limitation from congestion. Smell: zero improvement — complete anosmia impacting appetite, pleasure of eating, and safety (unable to smell gas leaks, smoke, spoiled food). She has placed additional smoke detectors in her home. Quality of life (SNOT-22 score today: 48 — moderate-severe, down from 82 at last pre-op visit, but anosmia domain driving ongoing burden). Sleep: improved — no more mouth breathing. Work: she is a food photographer; anosmia is profoundly impacting her professional work and she is experiencing significant emotional distress about this.

### 3g PERTINENT NEGATIVES

Denies epistaxis, purulent drainage, or fever. No CSF rhinorrhea. No vision changes or periorbital swelling. No new headaches. No facial paresthesias. No diplopia. No significant facial swelling. No worsening asthma attacks. No aspirin or NSAID use since surgery.

## ROS ENT Review of Systems

### 4 PERTINENT POSITIVES & NEGATIVES

- **Hearing loss / tinnitus / otalgia / otorrhea:** Denied — bilateral ears asymptomatic
- **Nasal obstruction / congestion:** POSITIVE — mild bilateral, left > right; early recurrence concern
- **Facial pressure / smell disturbance:** Pressure resolved; POSITIVE anosmia — complete, persistent
- **Sore throat / dysphagia:** Mild throat clearing from PND
- **Neck mass / thyroid / salivary:** Denied
- **Dizziness / vertigo:** Denied
- **Rhinorrhea / postnasal drip:** Mild PND; no anterior rhinorrhea
- **Epistaxis:** Denied
- **Hoarseness / voice change / cough:** Mild exertional wheeze (asthma-related)
- **Fever / weight loss / night sweats / fatigue:** Denied

## O Objective

### 5 INTERVAL ENT FINDINGS

#### V VITAL SIGNS

##### Temperature

98.0°F

##### Heart Rate

72 bpm

##### Oxygen Saturation

97% on room air

##### Pain Score

1/10 — mild nasal fullness left side

##### Blood Pressure

122/76 mmHg

##### Respiratory Rate

16 breaths/min

##### Height / Weight

5'5" / 158 lbs (BMI 26.3)

### 5a GENERAL APPEARANCE

Well-appearing, well-groomed female in no acute distress. Breathing comfortably through both nostrils at rest. Voice: clear, no hoarseness. Alert and engaged. Mild nasal quality to voice consistent with residual edema.

## 5b HEAD & FACE / EYES

### Head & Face

No facial tenderness on sinus palpation (frontal, maxillary, ethmoid) — significant improvement from pre-op. No periorbital edema. No facial swelling. Surgical approach was entirely endonasal — no external scars.

### Eyes

EOMs intact bilaterally. No proptosis, no diplopia. Periorbital region: no edema or ecchymosis.

## 5c EAR EXAM

Bilateral ears: External ears intact. Canals clear. Tympanic membranes: normal bilaterally — landmarks, light reflex, and mobility intact. No effusion, erythema, or retraction. No mastoid tenderness. Hearing subjectively intact to finger rub bilaterally.

## 5d NASAL EXAM

External nose: normal, no external swelling or deformity. ANTERIOR RHINOSCOPY: Right: mucosa mildly edematous, turbinates reduced, sinus ostia appear widely patent without gross polyp recurrence on anterior inspection. Left: more edematous turbinate and early gelatinous-appearing tissue at the left middle meatus region — consistent with early polyp recurrence. No fresh blood or purulent discharge. Nasal septum: mild left deflection (pre-existing, not surgically addressed). Confirmed on nasal endoscopy (see procedures section).

## 5e ORAL CAVITY / OROPHARYNX

Oral cavity: normal. Mild cobblestoning of posterior pharyngeal wall — consistent with chronic postnasal drip / allergic/LPR component. Tonsils: grade 1 bilateral, no erythema. Uvula: midline. No oral lesions.

## 5f NECK

Neck: supple, no palpable lymphadenopathy. No masses. Thyroid: not enlarged, no nodules palpable. Trachea midline. No carotid bruit.

## PP Procedures Performed

### 6 ENT PROCEDURES THIS VISIT

NASAL ENDOSCOPY (bilateral, in-office): Indication: 3-month post-FESS surveillance, evaluation of early polyp recurrence concern, and sinus healing assessment. Technique: 4% lidocaine + 0.05% oxymetazoline pledgets applied bilateral nasal cavities x5 min. Karl Storz 0° and 30° rigid 4.0mm Hopkins rod endoscope introduced sequentially bilateral nasal passages. Findings: RIGHT NASAL CAVITY: Ethmoid cavities widely patent, lateralization of middle turbinate not present. Right maxillary antrostomy widely patent — mucosa mildly edematous, no recurrent polyps visible. Right sphenoid and frontal sinuses patent. No crusting. Clean mucosal healing consistent with excellent surgical outcomes. LEFT NASAL CAVITY: Ethmoid cavities patent; however: small gelatinous-appearing polyp (approximately 5 x 4 mm) identified at the left middle meatus originating from the left ethmoid region — consistent with early focal recurrence. Left maxillary antrostomy patent. Left sphenoid and frontal sinuses: patent. Mild edema of the left lateral nasal wall mucosa. BILATERAL OLFACTORY CLEFT: Mucosa edematous bilaterally; olfactory cleft partially obscured by edema on both sides — this is likely contributing to persistent anosmia. No obvious mechanical obstruction of the olfactory cleft. Culture swab of bilateral middle meatus obtained. Patient tolerated procedure well — no complications.

## L Lab & Diagnostic Results

### 7 REVIEWED INTERVAL DATA

#### 7a AUDIOLOGY

No audiogram ordered — not indicated for this visit. Bilateral ears asymptomatic.

#### 7b IMAGING

No interval imaging obtained since surgery. Post-operative CT sinus NOT routinely ordered unless clinical concern for complication or recurrence requiring surgical reassessment. Given early polyp recurrence on endoscopy today, low-dose CT sinus will be ordered at the 6-month mark (approximately 08/2026) to provide objective recurrence documentation and guide biologic therapy authorization.

## 7c LABORATORY STUDIES / PATHOLOGY

Surgical pathology (02/2026): CRSwNP, eosinophilic pattern; eosinophil count 52/HPF (markedly elevated); Charcot-Leyden crystals, no malignancy, no fungal hyphae, AFB negative. Total serum IgE (ordered today): pending — baseline for biologic candidacy. CBC with differential (from pre-op labs, 01/2026): eosinophilia: 840 cells/ $\mu$ L (absolute eosinophil count — elevated). Allergy skin testing (performed 03/2026 by allergist Dr. Kim): positive to dust mites, cat dander, and tree pollen — confirmed allergic component. Samter triad (AERD) confirmed: CRSwNP + asthma + NSAID sensitivity (patient has history of nasal swelling and asthma exacerbation after naproxen use in 2022). Middle meatus culture — pending (from today's endoscopy).

## A Assessment

### 8 INTERVAL ENT CLINICAL INTERPRETATION

Mrs. Holloway is a 58-year-old female with a complex, recalcitrant sinonasal disease profile — CRSwNP (Type 2 eosinophilic inflammation), comorbid moderate persistent asthma, confirmed AERD/Samter triad, and allergic sensitization — presenting at 3 months post-bilateral FESS with: (1) EARLY FOCAL POLYP RECURRENCE — left middle meatus 5 mm polyp on endoscopy today; right side clean. Recurrence at 3 months post-FESS in the context of eosinophilic CRSwNP with AERD is expected — this disease pattern has among the highest recurrence rates of any rhinosinusitis subtype. (2) PERSISTENT COMPLETE ANOSMIA — olfactory cleft edema present bilaterally on endoscopy; no clear mechanical obstruction. Anosmia likely multifactorial: pre-existing olfactory nerve damage from chronic inflammation + ongoing olfactory cleft edema. Prognosis for smell recovery is guarded given severity and duration. (3) SUBOPTIMAL ASTHMA CONTROL — moderate persistent asthma requiring frequent albuterol use; this is driven by the same underlying Type 2 eosinophilic inflammation driving her CRSwNP. (4) BIOLOGIC THERAPY CANDIDACY: Mrs. Holloway meets criteria for dupilumab (Dupixent) — FDA-approved for CRSwNP + comorbid asthma in adults who are not adequately controlled on intranasal corticosteroids, particularly in the context of eosinophilic/Type 2 disease. This is the preferred next step over repeat surgery at this point.

## P Plan

### 9 FOLLOW-UP MANAGEMENT

#### 9a MEDICATIONS & SUPPORTIVE CARE

1. Continue mometasone 200 mcg BID nasal — spray technique reviewed and confirmed correct. 2. Continue NeilMed saline irrigation BID. 3. Add budesonide sinus rinse (0.5 mg/2 mL ampule in 240 mL saline) x1 irrigation per day — in addition to plain saline irrigation. This provides direct topical steroid to the surgical cavities and olfactory region. 4. Aspirin desensitization protocol — initiate at next allergy/immunology visit with Dr. Kim (reduces polyp recurrence in AERD patients; anti-inflammatory benefit for asthma and sinonasal disease). 5. Continue Advair 250/50 BID + montelukast — coordinate with pulmonologist for asthma optimization alongside biologic initiation.

#### 9b DIAGNOSTIC TESTING

Total serum IgE — pending (ordered today; baseline for biologic authorization). CBC with differential eosinophil count — ordered today (prior eosinophilia 840/ $\mu$ L; monitoring for biologic candidacy and response). Middle meatus culture — pending (from today's endoscopy). Fractional exhaled nitric oxide (FeNO) — ordered today (marker of Type 2 eosinophilic airway inflammation; supports biologic candidacy documentation). Low-dose CT sinus — scheduled for 08/2026 (6-month post-op, for biologic prior authorization and polyp recurrence documentation). SNOT-22: completed today (score 48).

#### 9c BIOLOGIC THERAPY INITIATION

DUPILUMAB (Dupixent) prior authorization to be initiated today. Rationale: CRSwNP with eosinophilic pathology (52 eos/HPF), AERD, comorbid moderate persistent asthma, early post-FESS recurrence at 3 months, inadequate control on max-dose intranasal corticosteroids. Dr. Reid to coordinate with Dr. Chen (pulmonology) and Dr. Kim (allergy/immunology) for unified biologic management (dupilumab addresses both asthma and CRSwNP simultaneously — Type 2 inflammation target). Insurance PA process initiated; patient counseled on dupilumab mechanism, SQ injection (300 mg Q2 weeks), expected timeline for smell improvement (3–6 months per LIBERTY NP studies), and common side effects (injection site reaction, conjunctivitis). Patient expresses strong interest given profound QOL impact of anosmia.

#### 9d PATIENT EDUCATION & REFERRALS

1. Olfactory training: patient instructed on standardized olfactory training protocol (rose, eucalyptus, lemon, clove — 2x daily for 3–6 months) to promote neuroplasticity and smell recovery; printed protocol provided. 2. Safety counseling: home safety measures for anosmia (additional smoke/CO detectors, gas detector, smell-check protocol for food freshness). 3. Patient given emotional support resources — anosmia is profoundly impacting her professional work; referral to AbScent (anosmia support organization) and patient community provided. 4. Aspirin desensitization referral confirmed with Dr. Kim (allergy/immunology). 5. Pulmonology: message to Dr. Chen re: biologic coordination for asthma. 6. No repeat surgery recommended at this time — biologic therapy is the preferred step before considering revision FESS.

**F Follow-Up**

**10 REASSESSMENT PLAN**

**Follow-Up Schedule**

Culture results: 05/09/2026 (phone). Dupilumab PA status: 05/15/2026 (pharmacy coordination). Follow-up ENT visit: 08/2026 (3 months) — endoscopy, CT sinus, SNOT-22, smell assessment. Aspirin desensitization: coordinate with allergy/immunology. Pulmonology for asthma: 06/2026 (per Dr. Chen).

**TIME DOCUMENTATION & BILLING**

**Total Time**

42 minutes

**E/M Level**

99214 — Established patient, moderate complexity

**Counseling / Coordination Time**

15 minutes

**Procedure Code(s)**

31237 — Nasal endoscopy, bilateral (31237)

**Basis for Billing**

Medical Decision Making — Moderate Complexity

**Primary ICD-10 Code**

J33.9 — Nasal polyp, unspecified

**Secondary ICD-10 Code(s)**

J32.9 — Chronic sinusitis, unspecified; J45.50 — Severe persistent asthma, uncomplicated; R43.0 — Anosmia; J30.9 — Allergic rhinitis; Z96.89 — Presence of other specified functional implants (post-FESS)

**PHYSICIAN NAME, MD**

Jonathan S. Reid, MD

**SPECIALTY**

MD — Otolaryngology / Rhinology | Board Certified (ABOto)

**DATE**

05/06/2026, 11:30 AM

**TIME**