1 Patient Information

1 PATIENT DETAILS

Name
Robert M. Castillo

Date of Service
05/06/2026

DOB
07/23/1984

Provider
Dr. Alicia N. Brown, MD — Otolaryngology / Rhinology

Age / Sex
41 / Male

MRN
ENT-2026-0512

Visit Type
Sinusitis / Sinonasal Evaluation — Recurrent Acute-on-Chronic

Reason for Visit
Recurrent acute bacterial rhinosinusitis, 6th episode in 18 months, failed multiple antibiotics, referred by PCP for surgical evaluation

CC Chief Complaint

2 PRIMARY SINONASAL CONCERN

Mr. Castillo is a 41-year-old male presenting with an 18-month history of recurrent acute bacterial rhinosinusitis (ABRS), now in his 6th episode since November 2024. He states: 'I get a sinus infection every 2–3 months and antibiotics work for a while but it always comes back worse. My face is killing me, I can barely breathe through my nose, and I've had a constant headache for 3 weeks. My doctor says I might need sinus surgery.' The current episode began approximately 3 weeks ago with facial pressure, purulent green nasal drainage, and fever to 101°F at onset. He has not responded to 2 weeks of amoxicillin-clavulanate.

S Subjective

3 PATIENT-REPORTED SINONASAL SYMPTOMS, HISTORY & TREATMENT

3a SYMPTOM ONSET & DURATION

Current episode: onset 04/15/2026 (3 weeks ago) — acute on a background of chronic sinonasal symptoms. Acute symptoms: right-sided facial pressure/pain, bilateral purulent green nasal drainage, fever 101°F at onset (now resolved), and worsening nasal obstruction. He has never had a symptom-free period of more than 6–8 weeks in the past 18 months. Prior episodes: November 2024 (first treated episode), January 2025, March 2025, June 2025, October 2025, and now April–May 2026. Each episode lasting 3–5 weeks. The current episode has been the longest and most symptomatic to date.

3b NASAL OBSTRUCTION / CONGESTION

Side
Bilateral, right > left — constant

Pattern
Constant, not positional; complete obstruction right side; 75% obstruction left side

Severity
9/10 obstruction right; 7/10 left. Cannot breathe through right nostril at rest.

3c NASAL DRAINAGE

Color / Consistency / Amount
Bilateral thick green purulent drainage, heavy — soaking through 6–8 Kleenex/hour during peak

Direction
Anterior and posterior; postnasal drip causing persistent sore throat and productive cough

Odor
Malodorous — notices foul smell from nose; wife has also commented

3d FACIAL PAIN / PRESSURE

Right-sided maxillary and frontal sinus pressure — 8/10 constant, 10/10 when bending forward. Right cheek and right forehead pain radiating to right upper teeth (dental pain from maxillary sinus pressure — dentist evaluation negative for dental pathology 2 weeks ago). Left frontal and maxillary pressure 5/10. Pain has not responded to ibuprofen or acetaminophen. Sleep severely disrupted by pain — averaging 4 hours/night.

3e SMELL DISTURBANCE

Bilateral hyposmia — significantly reduced smell during this episode. Has had intermittent hyposmia with prior episodes but smell returned during antibiotic courses. No complete anosmia or parosmia. Baseline smell was normal between episodes for the first several recurrences; now reports that even between episodes his smell has been somewhat reduced for the past 3–4 months.

3f ASSOCIATED SYMPTOMS

Persistent frontal headache (8/10, bifrontal, pressure-type) — present constantly for 3 weeks, worse with bending or exertion. Right upper dental pain — maxillary sinus-referred (dental exam negative). Persistent nonproductive cough from PND — waking him at night. Ear pressure bilaterally (worse left) — no hearing loss or otalgia. Low-grade fatigue — rating energy as 3/10. No fever currently (was 101°F at onset, now resolved). No itchy eyes (not allergic this episode). Halitosis noted by wife and coworkers.

3g RECURRENT / CHRONIC HISTORY

6 documented episodes of ABRS in 18 months — meeting criteria for recurrent acute rhinosinusitis (RARS: ≥4 episodes/year, each >10 days, with symptom-free intervals). History of seasonal allergic rhinitis to tree pollen and dust mites (skin testing positive, 2023). Mild persistent asthma — on budesonide/formoterol 160/4.5 mcg BID; well-controlled between sinus episodes but worsens with each sinus infection. History of deviated nasal septum noted on nasal exam in 2020 by PCP — never formally evaluated or treated. No prior nasal polyps identified. No immune deficiency workup performed. Work environment: high school teacher — exposure to sick children, dusty classrooms with poor ventilation. No exposure to cigarette smoke (never smoker; wife is non-smoker).

3h PRIOR TREATMENTS

Prior antibiotic courses this episode: Amoxicillin-clavulanate 875/125 mg BID x14 days (04/15–04/29) — minimal improvement; switched by PCP. Now on levofloxacin 500 mg daily x10 days (04/30–05/09, day 6 today) — partial improvement in fever and drainage color but no significant improvement in obstruction or facial pain. Other courses in past 18 months: amoxicillin x2 courses (inadequate duration per current guidelines), doxycycline x1 course. Saline irrigations: uses NeilMed once daily — inconsistently (3–4x/week). Fluticasone nasal spray 50 mcg BID: using but ran out 2 weeks ago and did not refill. Antihistamine: loratadine 10 mg PRN (uses occasionally). Decongestant: oxymetazoline nasal spray — been using for 2 weeks continuously (rhinitis medicamentosa risk). No prior sinus surgery. No prior ENT evaluation. Allergy immunotherapy: recommended in 2023 but patient declined due to time commitment.

3i PERTINENT NEGATIVES

Denies periorbital swelling or erythema. No vision changes or diplopia. No severe frontal headache with fever suggesting intracranial complication. No altered mental status. No neck stiffness. No facial numbness or paresthesias. No epistaxis. No orbital pain or proptosis. No neurologic deficits. No dental abscess identified (dental exam negative). No foreign body in nose. No unilateral symptoms only (bilateral, right-dominant).

ROS ENT Review of Systems

4 PERTINENT POSITIVES & NEGATIVES

- **Nasal obstruction / congestion:** POSITIVE — bilateral constant, right complete
- **Facial pressure / sinus pain:** POSITIVE — bilateral maxillary and frontal, right-dominant, 8/10
- **Headache / dental pain:** POSITIVE — bifrontal 8/10; right upper dental pain
- **Cough / throat clearing:** POSITIVE — persistent nocturnal cough from PND
- **Allergy symptoms:** POSITIVE — known allergic rhinitis, seasonal
- **Vision changes / periorbital swelling:** Denied — red flag absent
- **Rhinorrhea / postnasal drip:** POSITIVE — heavy purulent bilateral; posterior PND causing cough
- **Smell disturbance:** POSITIVE — bilateral hyposmia, progressive
- **Fever / chills / fatigue:** Fever resolved; fatigue 3/10 energy
- **Ear pressure:** POSITIVE — bilateral aural fullness, left > right
- **Epistaxis:** Denied

O Objective

5 MEASURABLE & OBSERVED SINONASAL FINDINGS

V VITAL SIGNS

Temperature
98.6°F (afebrile today; was 101°F at onset)

Blood Pressure
124/78 mmHg

Heart Rate
80 bpm

Respiratory Rate
16 breaths/min

Oxygen Saturation
97% on room air

Height / Weight
5'9" / 182 lbs (BMI 26.9)

Pain Score
8/10 facial pain; 3/10 at rest without movement

5a GENERAL APPEARANCE

Well-appearing but clearly uncomfortable male. Slightly nasal voice quality. Breathing predominantly through mouth at rest. No acute distress. No periorbital swelling or facial asymmetry. Cooperative throughout examination.

5b HEAD & FACE

Facial symmetry intact. No periorbital erythema or swelling. RIGHT MAXILLARY SINUS: Exquisite direct tenderness to percussion over the right cheek (right maxillary sinus region) — 9/10 pain elicited. RIGHT FRONTAL SINUS: Significant tenderness over the right supraorbital ridge (right frontal sinus). LEFT MAXILLARY AND FRONTAL: Mild-moderate tenderness bilaterally. No fluctuance. No facial swelling over sinuses. No facial nerve weakness.

5c EYES

Extraocular movements intact bilaterally. No proptosis. No periorbital edema or erythema. Conjunctivae clear. Sclerae non-icteric. No chemosis. No nystagmus.

5d EAR EXAM

Bilateral ears: External ears intact. Canals clear. RIGHT TM: Mildly retracted — reduced mobility on pneumatic otoscopy; small amount of air-fluid level visible behind right TM (consistent with ETD/right middle ear effusion). LEFT TM: Normal landmarks and mobility. No erythema, bulging, or perforation bilaterally. Mild bilateral aural fullness consistent with Eustachian tube dysfunction from sinonasal inflammation.

5e NASAL EXAM

External nose: midline, no deformity or external swelling. ANTERIOR RHINOSCOPY: RIGHT: Severely deviated nasal septum to the right — estimated 70% obstruction of the right nasal airway. Inferior turbinate hypertrophy (bilateral, right > left). Right inferior turbinate: markedly enlarged, pale/boggy (consistent with allergic rhinitis + current infection). Heavy thick green mucopurulent discharge in the right nasal cavity — both anterior and posterior. Right middle meatus: not well visualized due to turbinate hypertrophy and secretions. LEFT: Moderate inferior turbinate hypertrophy. Mild yellow-green mucopurulent discharge. Left middle meatus: partially visible — edematous, no polyps seen anteriorly. Nasal mucosa: diffusely erythematous and edematous bilaterally. No discrete masses or polyps visible on anterior rhinoscopy. NOTE: Oxymetazoline dependence suspected (14 days of continuous use per patient report).

5f ORAL CAVITY / OROPHARYNX

Posterior pharyngeal wall: heavy mucopurulent postnasal drainage coating the posterior pharynx — green-yellow, thick. Cobblestoning of posterior pharynx consistent with chronic postnasal drip. Tonsils: grade 1 bilateral, mildly erythematous. No exudate. Uvula: midline. Oral mucosa: normal. No lesions. Mild throat erythema consistent with PND irritation.

5g NECK & RESPIRATORY

Neck
Mild bilateral anterior cervical lymphadenopathy — level I/II nodes, tender, approximately 1 cm each. No dominant mass. No thyroid enlargement.

Respiratory
Mild accessory muscle use — predominantly mouth breathing. No stridor or wheeze at rest. Lungs: clear to auscultation bilaterally. No active asthma exacerbation today.

PP Procedures Performed

6 SINONASAL PROCEDURES THIS VISIT

NASAL ENDOSCOPY (bilateral, in-office): Indication: recurrent acute-on-chronic rhinosinusitis, evaluation of anatomic contributors, middle meatus and sinus patency assessment, and culture collection. Technique: 4% lidocaine + oxymetazoline (0.05%) pledgets bilateral nasal cavities x5 minutes. Karl Storz 0° and 30° rigid 4.0mm Hopkins rod endoscope inserted sequentially. Findings: RIGHT NASAL CAVITY: Severely deviated nasal septum to the right as described — endoscope passage significantly limited through the right nasal cavity. Right middle meatus: grossly edematous, polypoid mucosa, with active mucopurulent discharge draining from the right maxillary ostium. Right uncinate process: hypertrophied. No frank

polyps identified beyond polypoid mucosal changes. Culture swab obtained from right middle meatus (sent to lab for culture and sensitivity). RIGHT FRONTAL RECESS: Not visualized on initial attempt — obscured by edema and deviated septum. LEFT NASAL CAVITY: Mild inferior turbinate hypertrophy; middle meatus edematous but less severely than right. Left maxillary ostium: patent but ringed with edematous mucosa. Left frontal recess: open. LEFT MIDDLE MEATUS culture also obtained. Patient tolerated procedure with mild discomfort — no complications.

L Lab & Diagnostic Results

7 REVIEWED DATA

7a IMAGING

No prior CT sinus imaging in the system. CT SINUS WITH CORONAL RECONSTRUCTIONS ORDERED TODAY (WITHOUT CONTRAST): To assess bilateral sinus opacification, osteomeatal complex obstruction, anatomic variants (septum, concha bullosa, Haller cells), extent of disease, and surgical planning. Scheduling initiated. Imaging appointment: 05/08/2026. Results to be reviewed at follow-up. No MRI indicated at this time (no intracranial complication concern and no malignancy features).

7b LABORATORY STUDIES

No labs ordered at this visit. Previous CBC (ordered by PCP 04/15/2026 at episode onset): WBC 13.8 x10³/µL (leukocytosis consistent with acute bacterial infection); neutrophils 78% — confirming bacterial rather than viral process. CRP and ESR not formally ordered. No immune deficiency workup to date. IMMUNE WORKUP CONSIDERATIONS: Given recurrent ABRS (6 episodes/18 months), quantitative immunoglobulins (IgG, IgA, IgM, IgE, IgG subclasses), complement levels, and CBC with differential will be ordered at follow-up — to exclude common variable immunodeficiency (CVID), IgG subclass deficiency, or other primary immune deficiency contributing to recurrence.

7c CULTURES & PRIOR RECORDS

Cultures: Middle meatus swabs — bilateral, collected today. Lab processing pending x48–72h for organism identification and sensitivity testing. Prior antibiotics (as noted in subjective): amoxicillin-clavulanate (14 days, partial response), now on levofloxacin. Culture will guide further antibiotic selection — particularly important given poor response to broad-spectrum amoxicillin-clavulanate. Allergy records: reviewed from 2023 — positive skin testing to dust mites, tree pollens, and cockroach. Immunotherapy was recommended but declined. Prior ENT notes: none — first ENT evaluation.

A Assessment

8 SINUSITIS CLINICAL INTERPRETATION

Mr. Castillo is a 41-year-old male presenting with recurrent acute bacterial rhinosinusitis (RARS) meeting formal criteria (6 distinct ABRS episodes in 18 months, each lasting >10 days with acute symptoms, with partial symptom-free intervals). His current episode represents the most severe to date and has failed standard-duration amoxicillin-clavulanate, consistent with antibiotic-resistant organisms. Contributing factors driving recurrence are multiple and synergistic: (1) ANATOMIC OBSTRUCTION — severely deviated nasal septum to the right (estimated 70% right airway obstruction on endoscopy) combined with bilateral inferior turbinate hypertrophy is creating mechanical obstruction of the right osteomeatal complex (OMC) and impeding mucociliary clearance; (2) ALLERGIC RHINITIS — confirmed perennial allergen sensitization (dust mites, cockroach) causing chronic mucosal edema and turbinate hypertrophy, further compromising OMC drainage; (3) ASTHMA — unified airway disease; sinus inflammation and asthma are co-driving each other through the united airway concept; (4) OXYMETAZOLINE OVERUSE (14 days) — contributing to rhinitis medicamentosa and rebound congestion. No nasal polyps identified on endoscopy today. No immune deficiency workup yet — pending. Culture results pending. CT imaging ordered for surgical planning. This patient is a clear candidate for functional endoscopic sinus surgery (FESS) combined with septoplasty and bilateral inferior turbinate reduction, pending CT confirmation of anatomy and disease extent, completion of current antibiotic course, and optimized medical therapy trial.

P Plan

9 SINONASAL MANAGEMENT

9a MEDICAL THERAPY

1. Complete current levofloxacin course through 05/09 (day 10 total). Adjust antibiotic based on culture results when available (05/08–09). If culture shows resistant organism, will adjust accordingly. 2. DISCONTINUE oxymetazoline immediately — taper with saline flushes. 3. RESTART fluticasone nasal spray 50 mcg BID immediately — technique re-instructed (head-down, angling laterally, not inhaling forcefully). 4. INCREASE saline irrigations to BID (morning and evening) — consistent use emphasized. 5. Montelukast 10 mg PO daily added — benefit for allergic rhinitis + asthma unified airway disease. 6. Continue loratadine 10 mg daily (upgrade to fexofenadine 180 mg daily for superior efficacy). 7. Oral prednisone NOT prescribed at this time — will consider short burst if CT shows extensive disease and no contraindications. 8. Continue asthma medications per current regimen.

9b DIAGNOSTIC TESTING

CT sinus with coronal reconstructions — 05/08/2026. Quantitative immunoglobulins (IgG/IgA/IgM/IgG subclasses 1–4/IgE), complement (C3, C4, CH50) — ordered today (immune deficiency screen for RARS). Middle meatus cultures (bilateral, collected today) — results in 48–72h. CBC with differential — ordered. Allergy skin re-testing or specific IgE testing: recommend re-evaluation and allergy immunotherapy initiation as adjunct to surgical treatment; referral placed to Dr. Kim (Allergy/Immunology).

9c PROCEDURE / SURGICAL PLANNING

SURGICAL CANDIDACY: Mr. Castillo meets criteria for surgical intervention: RARS (≥4 episodes/year), anatomic obstruction (deviated septum, turbinate hypertrophy), failure of maximal medical therapy. PLANNED PROCEDURE (pending CT review): Bilateral FESS (bilateral maxillary antrostomy, bilateral anterior ethmoidectomy, bilateral frontal sinusotomy) COMBINED WITH septoplasty (right-deviation correction) and bilateral inferior turbinate reduction (submucosal resection). Surgical planning discussion initiated today. Risks, benefits, and alternatives presented: risks include bleeding, CSF leak (<0.5%), orbital injury (<0.1%), need for revision surgery; benefits include improved sinus drainage, reduced infection recurrence, improved nasal breathing and QOL; alternatives include continued medical therapy alone (likely insufficient given RARS with anatomic obstruction). Patient expresses strong interest in surgical treatment. Full surgical consent to be completed at next visit after CT review.

9d PATIENT EDUCATION & REFERRALS

1. Oxymetazoline discontinuation explained — rhinitis medicamentosa risk, rebound congestion to be expected for 5–7 days. 2. Nasal spray technique demonstrated with flip chart. 3. Saline irrigation: NeilMed high-volume BID emphasized — rinsed the bottle and instructed on proper maintenance. 4. Warning signs requiring ER: fever >102°F, severe headache, stiff neck, vision changes, periorbital swelling or redness, altered mental status, worsening despite antibiotics. 5. Allergy/Immunology referral placed — Dr. Angela Kim, MD. 6. Oxymetazoline discontinuation plan: use saline spray Q2h for the next 5–7 days to manage rebound.

F Follow-Up

10 REASSESSMENT PLAN

Follow-Up Schedule

CT results + culture results review: 05/09/2026 (telephone call). Follow-up clinic visit: 05/13/2026 — CT review with patient, immune workup results, symptom reassessment, finalize surgical plan, obtain informed consent for FESS + septoplasty. Surgery tentatively targeted for early June 2026 (pending CT, labs, and anesthesia clearance).

TIME DOCUMENTATION & BILLING

Total Time
48 minutes

E/M Level
99204 — New patient, moderate-high complexity

Counseling / Coordination Time
15 minutes

Procedure Code(s)
31237 — Nasal/sinus endoscopy, diagnostic/surgical bilateral

Basis for Billing
Medical Decision Making — High Complexity

Primary ICD-10 Code
J32.9 — Chronic sinusitis, unspecified; J01.90 — Acute sinusitis, unspecified

Secondary ICD-10 Code(s)
J30.9 — Allergic rhinitis; J34.2 — Deviated nasal septum; J45.30 — Mild persistent asthma; R43.1 — Parosmia/hyposmia

PHYSICIAN NAME, MD	SPECIALTY	DATE	TIME
Alicia N. Brown, MD	MD — Otolaryngology / Rhinology | Board Certified (ABOto)	05/06/2026, 10:00 AM	