1 Patient Information

1 PATIENT DETAILS

Name
Marcus T. Drummond

Date of Service
05/06/2026

DOB
11/03/1971

Provider
Dr. Patricia N. Walsh, MD — Otolaryngology / Sleep Surgery

Age / Sex
54 / Male

MRN
ENT-2026-0944

Referral Source
Dr. Nathan Cole, MD — Sleep Medicine

Reason for Referral
Severe OSA (AHI 62), CPAP intolerant after 3 attempts, surgical evaluation requested

CC Chief Complaint

2 PRIMARY SLEEP-RELATED CONCERN

Mr. Drummond is a 54-year-old male presenting for ENT/sleep surgery consultation for severe obstructive sleep apnea (OSA) that has not been managed by CPAP after three separate documented attempts over 4 years. He states: 'I've tried the CPAP machine three times and I cannot tolerate it. My wife sleeps in another room because of my snoring. My oxygen drops dangerously low and I fell asleep at a red light last month. I'm exhausted all the time and scared I'm going to have a heart attack in my sleep.' Referred by Dr. Cole (sleep medicine) for surgical evaluation including possible hypoglossal nerve stimulation (Inspire) or upper airway surgery.

S Subjective

3 PATIENT-REPORTED SLEEP SYMPTOMS, RISK FACTORS & ENT HISTORY

3a SLEEP SYMPTOMS & DURATION

SNORING: Severe, loud — wife describes it as 'like a lawnmower,' audible through closed door. Lifelong snorer. WITNESSED APNEAS: Wife witnesses 5–8 apnea episodes per hour — gasping and choking that sometimes wakes him. GASPING/CHOKING: Wakes himself gasping 3–4 times per night. RESTLESS SLEEP: Constant tossing and pillow kicking. NOCTURIA: 3x/night (OSA-related — increased ANP from intrathoracic pressure changes). MORNING HEADACHES: Every morning, rated 5/10. DRY MOUTH: Severe morning xerostomia daily. NON-RESTORATIVE SLEEP: Never feels rested regardless of hours slept.

3b DAYTIME SYMPTOMS

EXCESSIVE DAYTIME SLEEPINESS: Severe. Epworth Sleepiness Scale today: 18/24 (severe pathologic sleepiness; normal <10). Falls asleep involuntarily during television, at desk, and at stop lights — one documented red-light sleep episode 1 month ago (did not have an accident). He is a regional sales manager who drives 4–6 hours/week. PHQ-9 today: 11 (moderate depression — likely OSA-related). Two written employer performance reviews citing 'inconsistent focus and attention' in the past 18 months.

3c SLEEP SCHEDULE & QUALITY

Bedtime / Wake Time
10:30 PM / 6:30 AM (8 hours in bed — not restorative)

Sleep Latency
Rapid — falls asleep within 5 minutes (severe sleep deprivation)

Total Sleep Time (effective)
5–6 hours — severely fragmented by apneas

Naps
Unintentional 2–3x/day; intentional afternoon nap daily

3d AIRWAY / ENT SYMPTOMS

NASAL OBSTRUCTION: Significant bilateral nasal congestion — right > left, year-round (perennial). Mouth breathes exclusively during sleep and with exertion. Allergic rhinitis diagnosed 2019 on loratadine PRN (inconsistently). TONSILLAR ENLARGEMENT: Large tonsils noted by PCP as adult. Recurrent tonsillitis 2–3 episodes/year requiring antibiotics. DEVIATED SEPTUM: Noted 2021 by ENT but never treated. No prior airway surgery.

3e RISK FACTORS

BMI 41.2 (morbid obesity — has gained 32 lbs over 4 years). Neck circumference 18.5 inches (significant risk factor — >17 in males). Hypertension: amlodipine 5 mg + lisinopril 10 mg (BP 128/82 today). Type 2 DM: metformin 1000 mg BID + semaglutide 1 mg weekly (HbA1c 7.6%). Echocardiogram (04/2026): Mild RV dilation, RVSP 38 mmHg — consistent with chronic nocturnal hypoxemia. Family history: father had OSA. Alcohol: 2–3 drinks/night (significant — counseled; worsens OSA via pharyngeal muscle relaxation). Former smoker: quit 8 years ago, 12 pack-year history.

3f PRIOR EVALUATION & TREATMENT

PSG 2021: AHI 48, O2 nadir 82%. CPAP Attempt 1 (2021–22, nasal pillow, 9 months): average 1.4 hrs/night by data download; removed nightly due to claustrophobia. PSG/HSAT 2023: AHI 55, O2 nadir 79%. CPAP Attempt 2 (2023, auto full-face, 6 months): 0.6 hrs/night; severe aerophagia. CPAP Attempt 3 (2024, BiPAP hybrid, 4 months): 0.8 hrs/night; claustrophobia + insomnia. Most recent PSG (2025, Dr. Cole): AHI 62, O2 nadir 74%, 22% TST below 88%, sleep efficiency 61%, arousal index 54/hr, no central apneas. Objective CPAP failure confirmed — 3 attempts, all <1 hr/night. Oral appliance not attempted (Dr. Cole felt anatomy unsuitable). Semaglutide initiated 2024 — lost 8 lbs in 6 months.

3g TREATMENT TOLERANCE

CPAP intolerance after 3 objectively documented attempts (data downloads confirm <1 hr/night all three). Primary failure mechanisms: (1) claustrophobia/mask panic; (2) aerophagia on positive pressure; (3) nasal obstruction preventing nasal CPAP delivery. Patient is psychologically motivated and not refusing treatment — genuinely intolerant. Passed pre-surgical psychological screening per Dr. Cole's referral note.

3h PERTINENT NEGATIVES

No major drowsy driving accident (near-miss and red-light episode as noted). No syncope, no chest pain, no parasomnias with injury, no REM behavior disorder, no limb movement disorder. No swallowing difficulty. No voice change.

ROS Sleep / ENT Review of Systems

4 PERTINENT POSITIVES & NEGATIVES

- **Snoring / witnessed apneas / gasping:** POSITIVE — loud snoring, 5-8 witnessed apneas/hr, gasping waking 3-4x/night
- **Morning headaches / dry mouth:** POSITIVE — daily morning headaches + severe xerostomia
- **Nasal obstruction / congestion:** POSITIVE — bilateral, right > left, year-round, mouth breathing
- **Dysphagia / voice change / airway:** Denied
- **Drowsy driving:** POSITIVE — red-light sleep episode 1 month ago
- **Daytime sleepiness / fatigue:** POSITIVE — ESS 18/24, involuntary napping, red-light sleep episode 1 month ago
- **Insomnia / fragmented sleep:** POSITIVE — sleep efficiency 61% on PSG; fragmented by apneas
- **Mouth breathing / throat dryness:** POSITIVE — exclusively mouth breathes during sleep
- **Weight change:** POSITIVE — gained 32 lbs over 4 years
- **Mood changes / depression:** POSITIVE — PHQ-9 11, irritability, withdrawal

O Objective

5 MEASURABLE & OBSERVED UPPER AIRWAY FINDINGS

V VITAL SIGNS & SLEEP METRICS

Temperature	98.1°F
Blood Pressure	128/82 mmHg
Heart Rate	76 bpm
Respiratory Rate	16 breaths/min
SpO2	97% on room air
Height	5'11" (180 cm)
Weight	295 lbs (134.1 kg) — BMI 41.2 (Class III Obesity)
Neck Circumference	18.5 inches — significantly elevated (OSA risk threshold >17 in males)
ESS Score	18/24 — Severe pathologic sleepiness

5a GENERAL APPEARANCE

Obese, stocky male. Alert but nodded off briefly in waiting room per his own report. Mouth breathing at rest in exam room. No acute distress. Cooperative and motivated. Loud voice with mild nasal quality.

5b HEAD / FACE / EARS

Craniofacial Structure
Broad face, thick neck, mild retrognathia on profile view. No macroglossia on inspection. No craniofacial syndrome.

Ears
Bilateral: normal external ears, clear canals, normal TMs. No middle ear effusion.

5c NASAL EXAM

External nose: normal. Anterior rhinoscopy: Bilateral inferior turbinate hypertrophy grade 3/4 — turbinates contacting septum on the right. Moderate right-convex septal deviation — approximately 50% right airway obstruction, 30% left. Mucosa: pale/boggy bilaterally (allergic pattern). No polyps. No purulent discharge. Cottle maneuver: POSITIVE bilaterally — obstruction partially relieved with lateral nasal wall support.

5d ORAL CAVITY / OROPHARYNX — AIRWAY ASSESSMENT

Tongue Size / Position
Borderline macroglossia — large tongue relative to oral cavity, touching bilateral molars, tongue base crowding

Tonsil Size
GRADE 3 BILATERAL — tonsils extending to within 25% of oropharyngeal airway; significantly crowding

Uvula / Soft Palate
Elongated uvula 2.5 cm, contacting posterior tongue at rest. Soft palate: low-lying, thick.

Mallampati Score
CLASS IV — soft palate and uvula entirely obscured by tongue; no tonsillar pillars or posterior pharynx visible

Posterior Pharynx / Crowding
Severely crowded: large tonsils + elongated uvula + thick palate + tongue base crowding + retrognathia — multilevel obstruction

Dentition
Posterior molar wear pattern — bruxism, likely OSA-related

5e NECK & RESPIRATORY / AIRWAY

Neck
Thick neck 18.5 in. No lymphadenopathy. Thyroid: normal. Trachea: midline.

Respiratory / Airway
Mouth breathing at rest. SpO2 97%. No stridor. Clear to auscultation.

PP Procedures Performed

6 ENT / AIRWAY PROCEDURES THIS VISIT

FLEXIBLE NASOPHARYNGOSCOPY with MUELLER MANEUVER (in-office airway evaluation for sleep surgery planning): Indication: Comprehensive upper airway assessment in severe CPAP-intolerant OSA. Technique: 4% lidocaine + oxymetazoline decongestant bilateral nasal passages x5 min. 3.8mm Olympus ENF scope through right nasal cavity. Dynamic assessment: normal breathing, deep breathing, forced inspiration, and Mueller maneuver (maximum inspiratory effort against closed glottis to simulate upper airway collapse during sleep). Findings: NASAL PASSAGES: Severe right nasal obstruction even after decongestant. NASOPHARYNX: Mild lateral wall crowding, no adenoid tissue. OROPHARYNX: Grade 3 bilateral tonsils confirmed. Elongated uvula contacting tongue base at rest. MUELLER MANEUVER — OROPHARYNGEAL LEVEL: 80% anteroposterior collapse at retropalatal level + 60% bilateral lateral wall collapse. RETROLINGUAL LEVEL: Moderate tongue base collapse approximately 50% anteroposterior during Mueller. LARYNX: Bilateral vocal cord mobility intact. No supraglottic crowding. TOTAL ASSESSMENT: Multilevel obstruction — retropalatal (dominant) + retrolingual + lateral wall — all three levels involved. Pattern is relevant to surgical planning: multilevel disease means UPPP alone may be insufficient; tongue base procedure and/or weight loss to Inspire BMI threshold should be incorporated. Patient tolerated procedure well. No complications.

L Lab & Sleep Study Results

7 SLEEP APNEA-RELATED DATA

7a SLEEP STUDY RESULTS (MOST RECENT PSG, 2025)

Study Type / AHI / RDI
In-laboratory PSG (Dr. Cole, 2025): AHI 62/hr (Severe). RDI 68 including RERAs.

Oxygen Nadir / Time Below 88%
O2 nadir 74% (critically low). 22% of TST below 88% saturation.

Sleep Efficiency / Arousals
Sleep efficiency 61% (severely reduced). Arousal index 54/hr.

Positional / Central
AHI supine 84, non-supine 41. Central apnea index 0.2/hr — purely obstructive.

7b PAP THERAPY DATA — ALL 3 ATTEMPTS

Attempt 1 (2021–22, nasal pillow, 9 months): average 1.4 hrs/night by data download; residual AHI 28 (not therapeutic); claustrophobia. Attempt 2 (2023, auto full-face, 6 months): average 0.6 hrs/night; severe aerophagia; 8% adherence. Attempt 3 (2024, BiPAP hybrid, 4 months): average 0.8 hrs/night; claustrophobia + insomnia; 10% adherence. CPAP intolerance objectively confirmed — 3 attempts, all <1 hr/night over 4 years. Insurance CPAP intolerance criteria met for alternative therapies.

7c IMAGING / AIRWAY EVALUATION & LAB STUDIES

ECHOCARDIOGRAM (04/2026): Mild RV dilation, RVSP 38 mmHg (mildly elevated — pulmonary HTN from chronic nocturnal hypoxemia). EF 58% preserved. No wall motion abnormalities. ECG today: Normal sinus rhythm. LABS (PCP, 03/2026): HbA1c 7.6%, BMP WNL, TSH 2.2 (normal), CBC WNL. DRUG-INDUCED SLEEP ENDOSCOPY (DISE): ORDERED — to be performed under propofol sedation to characterize collapse pattern under sleep-simulated conditions and confirm surgical approach. Scheduled 05/19/2026.

A Assessment

8 SLEEP APNEA CLINICAL INTERPRETATION

Mr. Drummond is a 54-year-old male with SEVERE OSA (AHI 62, O2 nadir 74%, 22% TST <88%) representing a medically urgent situation — nocturnal hypoxemia is causing RV strain, daily drowsy driving risk, cognitive impairment, depression, and significant cardiovascular risk. CPAP intolerance is objectively documented after 3 verified attempts (all <1 hr/night). Surgical evaluation is medically appropriate and insurance-criteria compliant. ANATOMIC CONTRIBUTORS: (1) Morbid obesity BMI 41.2; (2) Grade 3 bilateral tonsillar hypertrophy; (3) Elongated uvula + low-lying thick soft palate; (4) Borderline macroglossia + tongue base hypertrophy; (5) Mallampati IV; (6) Bilateral nasal obstruction (deviated septum + grade 3 turbinates) — forces mouth breathing worsening collapse; (7) Mild retrognathia; (8) Neck circumference 18.5 in. MULTILEVEL OBSTRUCTION confirmed (Mueller maneuver: 80% retropalatal, 60% lateral wall, 50% retrolingual). SURGICAL CANDIDACY: (A) HYPOGLOSSAL NERVE STIMULATION (Inspire): AHI 62 within range but BMI 41.2 EXCEEDS Inspire limit (<32) — NOT currently a candidate. Weight loss to BMI <32 via bariatric intervention would open this option. (B) UPPER AIRWAY SURGERY: Septoplasty + bilateral turbinate reduction (Stage 1) + tonsillectomy + UPPP (Stage 2) + tongue base management as indicated by DISE. (C) WEIGHT LOSS: Highest-priority intervention — bariatric surgery referral placed. DISE required before finalizing surgical plan.

P Plan

9 SLEEP APNEA MANAGEMENT

9a DIAGNOSTIC TESTING

DISE (drug-induced sleep endoscopy): 05/19/2026 in OR under propofol. Will characterize collapse level, pattern, and Inspire candidacy if BMI reduced. Cephalometric X-ray: at DISE planning visit for skeletal structure. No additional sleep study needed — current PSG sufficient.

9b TREATMENT OPTIONS & PLAN

IMMEDIATE: (1) Positional therapy — non-supine sleep (positional device prescribed; AHI supine 84 vs non-supine 41). (2) Alcohol elimination before bedtime — strictly counseled; no alcohol within 4 hours of bedtime. (3) Nasal medical therapy: mometasone 200 mcg BID + fexofenadine 180 mg daily + saline irrigations BID. (4) Weight loss optimization: titrate semaglutide to 2 mg weekly. Bariatric surgery referral placed — BMI 41.2 with OSA + T2DM + HTN meets criteria; weight loss to BMI <32 would open Inspire candidacy. SURGICAL PLAN (pending DISE): Stage 1 — septoplasty + bilateral inferior turbinate reduction. Stage 2 — tonsillectomy + UPPP + tongue base management (specific procedure per DISE findings). Inspire re-evaluation: if bariatric surgery achieves BMI <32.

9c ENT-DIRECTED MANAGEMENT

Nasal obstruction: mometasone BID + fexofenadine + saline irrigations initiated. Deviated septum + turbinate hypertrophy: Stage 1 surgical correction. Grade 3 tonsils: tonsillectomy as part of Stage 2. Nasal correction alone may allow re-trial of CPAP or oral appliance at improved nasal patency — to be assessed after Stage 1.

9d PATIENT EDUCATION & REFERRALS

DROWSY DRIVING: Counseled in strongest terms — driving restriction until OSA treated; encouraged rideshare for long drives. Agreed to limit driving to essential short routes. BARIATRIC REFERRAL: Explained BMI-Inspire connection — strong motivation for weight loss. Dr. Torres referral placed 06/04/2026. ALCOHOL: Zero evening alcohol committed. SURGERY EXPECTATIONS: Combined upper airway surgery averages 50–60% AHI reduction in multilevel candidates; not a cure in severe obesity-related OSA but significant improvement. Full follow-up plan explained.

F Follow-Up

10 REASSESSMENT PLAN

Follow-Up Schedule

DISE: 05/19/2026. DISE results + surgical planning: 05/26/2026. Bariatric surgery consultation: 06/04/2026. Stage 1 nasal surgery: targeted June 2026. Sleep medicine coordination: message sent to Dr. Cole today.

TIME DOCUMENTATION & BILLING

Total Time
62 minutes

E/M Level
99205 — New patient, high complexity

Counseling / Coordination Time
25 minutes

Procedure Code(s)
31575 — Flexible nasopharyngoscopy (diagnostic airway evaluation)

Basis for Billing
Medical Decision Making — High Complexity

Primary ICD-10 Code
G47.33 — Obstructive sleep apnea (adult)

Secondary ICD-10 Code(s)
J34.2 — Deviated nasal septum; J35.3 — Hypertrophy of tonsils; E66.01 — Morbid obesity; I27.20 — Pulmonary hypertension, unspecified; F32.1 — MDD moderate

PHYSICIAN NAME, MD	SPECIALTY	DATE	TIME
Patricia N. Walsh, MD	MD — Otolaryngology / Sleep Surgery | Board Certified (ABOto)	05/06/2026, 10:00 AM	