1 Patient Information

1 PATIENT DETAILS

Name
Lorraine A. Chen

Date of Service
05/06/2026

DOB
03/04/1979

Provider
Dr. Steven R. Park, MD — Otolaryngology / Head & Neck Surgery

Age / Sex
47 / Female

MRN
ENT-2026-0892

Visit Type
Thyroid / Neck Mass Evaluation — Surgical Consultation

Mass Location / Laterality
Right thyroid lobe + right level III cervical lymph node

Referral Source
Dr. Laura Kim, MD — Endocrinology

CC Chief Complaint

2 PRIMARY THYROID / NECK MASS CONCERN

Ms. Chen is a 47-year-old female presenting for ENT/head and neck surgery consultation for evaluation of a right thyroid nodule (2.8 cm, ACR TI-RADS 4) with a right level III cervical lymph node (1.9 cm, suspicious), concurrent voice change, and mild dysphagia. She states: 'I felt a lump in my neck about 4 months ago. My endocrinologist found another node in the lymph gland area on ultrasound and now she wants a surgical opinion because the needle biopsy was indeterminate. I've also been noticing my voice is different — it sounds more breathy and I get tired when I talk — and I sometimes feel like food sticks in my throat.' Referred by endocrinologist (Dr. Laura Kim) after thyroid ultrasound and FNA (Bethesda III — atypia of undetermined significance) with ThyroSeq molecular testing returning high-risk result.

S Subjective

3 PATIENT-REPORTED NECK, THYROID & HEAD AND NECK SYMPTOMS

3a ONSET & COURSE

Right neck mass/thyroid fullness: first self-noticed approximately 4 months ago (January 2026) — patient felt a 'lump on the right side of my neck below my Adam's apple.' She initially attributed it to a lymph node from a recent upper respiratory infection. The mass has not resolved and appears to have slightly increased in size per patient's estimation. She reports a 1.9 cm adjacent lateral cervical node was identified on ultrasound that was not palpable to her. Thyroid ultrasound performed 03/12/2026 (per Dr. Kim): Right thyroid lobe nodule 2.8 cm, ACR TI-RADS 4, with suspicious features. US-guided FNA performed 04/08/2026 by Dr. Kim: Bethesda Category III (atypia of undetermined significance, AUS). ThyroSeq v3 molecular testing (performed on FNA specimen): RAS mutation detected — classified as HIGH RISK for malignancy (positive for NRAS codon 61 mutation; estimated malignancy risk 50–60% per ThyroSeq v3 data). Right level III lateral cervical lymph node FNA (04/22/2026): POSITIVE for metastatic thyroid carcinoma cells — confirming regional metastatic disease.

3b LOCATION & LATERALITY

(1) RIGHT THYROID LOBE: Anterior neck, right of midline, lower pole of right thyroid lobe. The mass moves with swallowing — consistent with thyroid origin. (2) RIGHT LEVEL III CERVICAL LYMPH NODE: Right lateral neck, approximately mid-jugular level, 1.9 cm. Palpable today. Both structures are right-sided. No left-sided thyroid nodule or lymph node reported on ultrasound. Trachea appears midline by patient report (no tracheal deviation).

3c MASS CHARACTERISTICS

RIGHT THYROID NODULE: Firm to hard on patient's self-palpation. Not tender. Does not fluctuate. Has not decreased in size. Overlying skin: intact, no erythema. RIGHT LEVEL III NODE: Firm, non-tender, non-mobile (as reported by Dr. Kim on exam). No skin changes or drainage. No warmth.

3d THYROID-RELATED SYMPTOMS

No heat or cold intolerance. No palpitations or tremor. Weight: stable (no unexplained weight loss or gain — explicitly checked). No fatigue beyond normal baseline. Hair and skin: normal. No bowel changes. No menstrual changes. No compressive symptoms beyond dysphagia and voice changes noted below. TSH: 1.8 mIU/L (normal) — no hyperthyroidism or hypothyroidism.

3e COMPRESSIVE / AERODIGESTIVE SYMPTOMS

VOICE CHANGE: Breathy, 'tired' voice developing over the past 2–3 months. She describes increasing vocal fatigue with prolonged speaking (phone calls, teaching — she is a university professor). Difficulty projecting voice in lecture halls. She describes her voice as 'weaker and more airy' than usual — consistent with possible right vocal cord paresis from right recurrent laryngeal nerve (RLN) involvement by the thyroid/neck mass. DYSPHAGIA: Mild — describes intermittent sensation of food sticking at the sternal notch level with dense solids (bread, meat) — 2–3 times per week. No odynophagia. No aspiration or coughing with meals. GLOBUS SENSATION: Intermittent right-sided throat fullness. DYSPNEA: None. STRIDOR: None.

3f INFECTIOUS / INFLAMMATORY SYMPTOMS

No fever, chills, or sore throat. No recent URI or dental infection preceding the mass. No skin infection at the neck. No rapid swelling or fluctuance. No pain at the thyroid nodule or neck node (painless thyroid mass is classically more concerning for malignancy — painful masses more often benign).

3g MALIGNANCY RISK FACTORS

Family history of thyroid cancer: POSITIVE — maternal aunt: papillary thyroid carcinoma (diagnosed age 52, treated with total thyroidectomy, well). Father: no thyroid disease. No personal history of prior cancer. RADIATION HISTORY: No prior neck or head radiation. No known exposure to radioactive iodine or external beam radiation. Tobacco: never smoker. Alcohol: social, 3-4 drinks/week. No hemoptysis. No unexplained weight loss. No prior neck surgery. Age and sex (47F): female sex and ages 25-60 are associated with increased thyroid malignancy risk.

3h PRIOR EVALUATION & TREATMENT

PRIOR WORKUP (all performed by Dr. Kim, endocrinology): Thyroid ultrasound 03/12/2026; FNA right thyroid nodule 04/08/2026 (Bethesda III, ThyroSeq NRAS+); FNA right level III LN 04/22/2026 (metastatic thyroid carcinoma). TSH 1.8 mIU/L (normal). No prior thyroid surgery, radioactive iodine, or endocrine surgery. No prior neck imaging beyond ultrasound. CT neck/chest has NOT been performed — ordered today for pre-operative staging. Patient has never seen a head and neck surgeon before this visit.

3i PERTINENT NEGATIVES

No airway compromise or stridor. No rapidly enlarging mass. No hemoptysis. No fever or night sweats. No unexplained weight loss. No bilateral supraclavicular lymphadenopathy. No neurologic deficits (arm/leg weakness, numbness, Horner syndrome). No dyspnea at rest. No complete dysphagia (liquid intake unimpaired).

ROS ENT / Thyroid Review of Systems

4 PERTINENT POSITIVES & NEGATIVES

- **Neck mass / thyroid / lymphadenopathy:** POSITIVE — right thyroid nodule 2.8 cm (TI-RADS 4) + right level III LN 1.9 cm (FNA+)
- **Neck pain / tenderness:** Denied — painless mass
- **Dysphagia / globus sensation:** POSITIVE — intermittent food sticking at sternal notch; right globus
- **Hoarseness / voice change:** POSITIVE — breathy voice, vocal fatigue x2-3 months
- **Dyspnea / stridor:** Denied
- **Fever / night sweats / weight loss:** Denied
- **Heat/cold intolerance / palpitations:** Denied — euthyroid clinically and biochemically
- **Family history of thyroid cancer:** POSITIVE — maternal aunt PTC

O Objective

5 MEASURABLE & OBSERVED FINDINGS

V VITAL SIGNS

Temperature
98.0°F

Blood Pressure
118/72 mmHg

Heart Rate
68 bpm

Respiratory Rate
14 breaths/min

Oxygen Saturation
99% on room air

Height / Weight
5'4" / 138 lbs (BMI 23.7)

Pain Score
0/10

5a GENERAL APPEARANCE

Well-appearing, well-groomed female in no distress. Voice: mildly breathy quality noted immediately on greeting — hypophonia with mild air escape on prolonged phonation. Swallowing comfortable with water sip during exam. Breathing comfortably — no stridor.

5b HEAD & FACE / EARS / NOSE

Head & Face
Facial symmetry intact. No facial masses or swelling. No jaw crepitus. CN VII intact. No Horner syndrome (no ptosis, miosis, anhydrosis).

Ears / Nose
Normal bilateral ears and nasal exam — not the primary concern at this visit.

5c ORAL CAVITY / OROPHARYNX

Oral cavity: normal. No lesions or masses. Oropharynx: tonsils grade 1 bilateral. Uvula: midline. No posterior pharyngeal fullness or asymmetry. Tongue: protrudes midline, no fasciculations. Soft palate elevation: symmetric.

5d NECK — PRIMARY FOCUS

Mass Location
Right thyroid lower pole — 2.8 cm firm, smooth-surfaced nodule palpable in the right inferior thyroid region; moves freely with swallowing (thyroid origin confirmed).

Size / Laterality
Right thyroid: 2.8 cm (correlates with ultrasound). Right level III: 1.9 cm firm, non-tender, slightly fixed to surrounding tissue.

Consistency (Firm/Hard)
Right thyroid nodule: firm-hard. Right level III node: firm, rubbery-to-hard.

Mobility
Thyroid nodule moves with deglutition — typical thyroid mobility. Level III node: slightly reduced mobility — concerning for extranodal extension.

Tenderness / Skin Changes
Not tender. Overlying skin: intact, no erythema, no tethering.

Tracheal Position
Trachea: midline — no tracheal deviation despite nodule size.

5e THYROID

Right thyroid lobe: enlarged, firm, palpable nodule at lower pole as described. No bruit over thyroid. Left thyroid lobe: normal size and consistency. No pain on thyroid palpation. No multinodular goiter palpable — ultrasound will have confirmed. Moves with swallowing — classic thyroid sign.

5f RESPIRATORY / AIRWAY & NEUROLOGICAL

Respiratory / Airway
Breathing comfortably. No stridor or wheeze. Clear to auscultation. SpO2 99%.

Cranial Nerves / Vocal Quality
Voice: breathy, mildly hypophonic. Phonation sustained 'eee': reduced — cut off at 9 seconds (normal >15 seconds). This is highly suspicious for right vocal cord paresis from right RLN involvement. CN VII intact. CN XI: shoulder shrug 5/5 bilateral.

PP Procedures Performed

6 ENT / NECK PROCEDURES THIS VISIT

FLEXIBLE LARYNGOSCOPY (in-office, diagnostic): Indication: Voice change in setting of right thyroid nodule + right level III positive LN — evaluation for right recurrent laryngeal nerve (RLN) involvement and vocal cord mobility. Technique: 4% lidocaine topical nasal spray bilateral nares. 3.8mm Olympus ENF flexible laryngoscope introduced through right nasal cavity. Findings: NASOPHARYNX: Normal. BASE OF TONGUE / HYPOPHARYNX: No masses. No pooling. LARYNX: RIGHT VOCAL CORD: PARETIC — the right true vocal cord is in the paramedian position at rest and fails to achieve full adduction on phonation or cough. LEFT VOCAL CORD: Full mobility — abducts fully on inspiration, adducts fully on phonation. Arytenoids: Right arytenoid: sluggish but mobile. False cords: symmetric. Epiglottis: normal. Subglottis: clear. The finding of right vocal cord paresis in the setting of a right thyroid malignancy with right level III nodal metastasis is consistent with right RLN involvement — either direct tumor invasion of the RLN or compression by the right level III positive node in the RLN course. This finding significantly impacts surgical planning and staging. Patient tolerated procedure well — no complications.

L Lab & Diagnostic Results

7 THYROID & NECK MASS DATA

7a IMAGING STUDIES

THYROID ULTRASOUND (03/12/2026, Dr. Kim's office): Right thyroid lobe — 2.8 x 2.1 x 1.9 cm nodule, lower pole. Features: solid, hypoechoic, irregular margins, punctate echogenic foci (microcalcifications — 2 identified), taller-than-wide shape. ACR TI-RADS SCORE: 4 (moderately suspicious — FNA warranted at this size, which was performed). Left thyroid lobe: No nodules. Isthmus: Normal. Right level III: 1.9 cm lateral cervical lymph node — round (loss of normal reniform shape), hyperechoic, microcalcification present. These LN features are highly suspicious for thyroid cancer metastasis. CT NECK AND CHEST WITH CONTRAST: ORDERED TODAY — pre-operative staging. To assess: (1) extent of right thyroid mass and relationship to RLN/trachea/esophagus; (2) right level III node — ENE, adjacent structure involvement; (3) additional cervical nodal disease not apparent on ultrasound; (4) pulmonary metastases. Scheduled 05/08/2026.

7b LABORATORY STUDIES

TSH (03/2026, per Dr. Kim): 1.8 mIU/L — normal (euthyroid). Free T4: 1.1 ng/dL (normal). Thyroglobulin: 68 ng/mL (elevated — consistent with thyroid malignancy). Anti-thyroglobulin antibodies: 12 IU/mL (low — thyroglobulin measurement valid, not interfered). Calcitonin: 4 pg/mL (normal — medullary thyroid carcinoma unlikely; normal calcitonin largely excludes MTC). CBC: WNL. CMP: WNL. Calcium 9.2 mg/dL (normal pre-op baseline).

7c PATHOLOGY / CYTOLOGY

FNA RIGHT THYROID NODULE (04/08/2026, ultrasound-guided, Dr. Kim): Bethesda Category III — Atypia of Undetermined Significance (AUS). Cell block prepared. ThyroSeq v3 Genomic Classifier performed on cell block: NRAS codon 61 mutation DETECTED. ThyroSeq v3 NRAS mutation in AUS nodule: estimated malignancy risk 50-60% (high-risk result per ThyroSeq v3 classification — strongly favors surgical resection). FNA RIGHT LEVEL III CERVICAL LYMPH NODE (04/22/2026, ultrasound-guided): POSITIVE for METASTATIC CARCINOMA consistent with PAPILLARY THYROID CARCINOMA (PTC) — cells with nuclear grooves, pseudoinclusions, and papillary architecture fragments. Thyroglobulin washout of needle: 1,840 ng/mL (markedly elevated — confirms thyroid carcinoma metastasis to the right level III node).

7d ENDOSCOPY FINDINGS & PRIOR RECORDS

Vocal Cord Mobility

RIGHT VOCAL CORD PARETIC — found on flexible laryngoscopy today. Consistent with right RLN involvement by thyroid malignancy and/or right level III nodal disease.

Prior Records

Endocrinology notes and ultrasound/pathology reports from Dr. Kim reviewed in full. No prior neck surgery or radiation records.

A Assessment

8 THYROID & NECK MASS CLINICAL INTERPRETATION

Ms. Lorraine Chen is a 47-year-old euthyroid female presenting with findings that together constitute a HIGH-PROBABILITY DIAGNOSIS OF PAPILLARY THYROID CARCINOMA (PTC) of the right thyroid lobe with metastatic right level III cervical lymph node disease, based on: (1) Right thyroid nodule 2.8 cm, ACR TI-RADS 4 (suspicious features: hypoechoic, irregular margins, microcalcifications, taller-than-wide); (2) FNA Bethesda III with ThyroSeq v3 NRAS mutation — 50-60% malignancy risk, well above the threshold for surgical resection; (3) Right level III LN FNA: POSITIVE for metastatic PTC (PTC nuclear features + thyroglobulin washout 1,840 ng/mL); (4) RIGHT VOCAL CORD PARESIS on laryngoscopy today — indicating right RLN involvement by either the primary thyroid mass (direct extension) or the metastatic level III node (compressing the RLN in its course in the tracheoesophageal groove). This finding advances clinical T staging toward T3 or potentially T4a (extrathyroidal extension with RLN involvement). STAGING (preliminary, pending CT): cT3b or cT4a, N1b (right level III), M0. SURGICAL PLAN: Total thyroidectomy + right modified radical neck dissection (central compartment + right lateral neck, levels II-V) is indicated. RLN monitoring will be critical intraoperatively. Parathyroid identification and preservation will be prioritized. Radioactive iodine (RAI) ablation to be discussed post-operatively with Dr. Kim (endocrinology) based on final pathology.

P Plan

9 THYROID & NECK MASS MANAGEMENT

9a DIAGNOSTIC EVALUATION

CT neck and chest with contrast — 05/08/2026 (pre-operative staging). Vocal cord mobility confirmed — no additional laryngeal imaging needed at this time. Pre-operative labs (to be drawn day of pre-op visit): CBC, CMP, calcium, PTH, coagulation panel, type and screen, TSH.

9b MEDICAL TREATMENT

No anti-thyroid medications (euthyroid). No steroids. Levothyroxine post-operatively will be discussed at pre-op visit — TSH-suppressive dosing will depend on final pathology and risk stratification.

9c SURGICAL PLANNING

PLANNED PROCEDURE: Total thyroidectomy + right modified radical neck dissection (central compartment, levels II-V right). TIMING: Scheduled for 05/27/2026. Intraoperative nerve monitoring (IONM) with continuous right RLN monitoring — mandatory given preoperative right vocal cord paresis (right RLN at risk). Parathyroid identification and auto-transplantation protocol (reimplantation into sternocleidomastoid if inadvertent devascularization). Consultation with Dr. Sarah Chen, MD (Anesthesiology) for pre-op clearance — cardiopulmonary evaluation for 47-year-old with no significant comorbidities (low risk). Risks, benefits, and alternatives discussed today: risks (RLN permanent injury, hypoparathyroidism, hematoma, infection, need for RAI, hypothyroidism requiring lifelong levothyroxine); benefits (definitive oncologic surgery, staging, cure of locoregional disease); alternatives (active surveillance — not appropriate given N1b confirmed disease, RLN involvement, and high-risk molecular result). Patient accepts surgical plan. Written surgical consent to be obtained at pre-op visit 05/20/2026.

9d REFERRALS & PATIENT EDUCATION

1. Continue follow-up with Dr. Kim (endocrinology) — post-operative management (levothyroxine dosing, RAI evaluation, thyroglobulin surveillance). 2. Otolaryngology/Voice: Post-operative voice rehabilitation will be assessed at 6-week follow-up — if right vocal cord paresis does not resolve post-operatively, vocal cord medialization (injection or thyroplasty) may be needed for voice improvement. 3. Speech therapy: Referral placed for pre-operative voice baseline and dysphagia assessment. 4. Patient education today: Explained diagnosis clearly — highly likely PTC; explained right vocal cord paresis finding and its surgical implications; explained total thyroidectomy and neck dissection procedure; explained post-operative hypothyroidism and lifelong levothyroxine; discussed RAI in general terms (details post-operative). Patient was tearful but composed. Husband to be present at 05/20 pre-op visit.

F Follow-Up

10 REASSESSMENT PLAN

Follow-Up Schedule

CT neck/chest: 05/08/2026. Pre-op clinic visit (CT review, consent, labs): 05/20/2026. Anesthesia pre-op: 05/21/2026. Surgery: 05/27/2026 at 07:00 AM. Post-op wound check: 06/03/2026. Pathology/RAI discussion: 06/10/2026 (with Dr. Kim and Dr. Park jointly).

TIME DOCUMENTATION & BILLING

Total Time
60 minutes

E/M Level
99205 — New patient, high complexity

Counseling / Coordination Time
25 minutes

Procedure Code(s)
31575 — Flexible laryngoscopy

Basis for Billing
Medical Decision Making — High Complexity

Primary ICD-10 Code
E04.1 — Nontoxic single thyroid nodule (pending final pathology — suspected PTC)

Secondary ICD-10 Code(s)
C73 — Malignant neoplasm of thyroid gland (pending); C77.0 — Secondary neoplasm cervical LN; J38.01 — Vocal cord paresis, right

PHYSICIAN NAME, MD	SPECIALTY	DATE	TIME
Steven R. Park, MD	MD — Otolaryngology / Head & Neck Surgery | Board Certified (ABOto)	05/06/2026, 2:00 PM	