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SAMPLE XEROSTOMIA EVALUATION SOAP NOTE

SEVERE SALIVARY HYPOFUNCTION — SUSPECTED PRIMARY SJÖGREN'S SYNDROME

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME	Eleanor V. Brightwater
DATE OF SERVICE	07/02/2026
DOB	03/28/1957
PROVIDER	Dr. Priya Raghunathan, DDS, MD — Oral Medicine
AGE / SEX	68 / Female
CREDENTIALS	DDS, MD, Diplomate ABOM
MRN / PATIENT ID	OM-70931e
VISIT TYPE	Xerostomia Evaluation (new referral)

REFERRAL SOURCE

Referred by Dr. M. Halloran (dentist) for severe dry mouth with rapidly progressive cervical/root caries; also under ophthalmology for dry eyes.

DENTAL / PRIMARY CARE PROVIDER

Dentist: Dr. Michael Halloran, DDS · PCP: Dr. A. Persaud, MD · Ophthalmology: Dr. L. Fenn, MD

CC CHIEF COMPLAINT

2 PRIMARY DRY MOUTH CONCERN

> *'My mouth is bone dry — I keep a water bottle everywhere and wake up several times a night to sip. My teeth are crumbling even though I brush, and my eyes burn too.'*

Duration: Eleanor reports ~2 years of progressive, severe dry mouth with nocturnal waking, difficulty eating dry foods without liquids, and **rapidly progressive cervical and root caries** despite good hygiene. The combination of **dry mouth + dry eyes + accelerated caries in an older woman** raises strong concern for **primary Sjögren's syndrome** rather than a purely medication-related cause.

S SUBJECTIVE

3 PATIENT-REPORTED XEROSTOMIA HISTORY

3a ONSET, SEVERITY & SALIVARY SYMPTOMS

- **Onset / course:** Gradual over ~2 years, steadily worsening; **persistent, not intermittent**, with prominent nocturnal dryness (wakes 2–3× nightly to sip water).
- **Severity & pattern:** Severe by patient report; difficulty speaking for long periods, **cannot eat dry foods (crackers, bread) without liquids**, and constant sipping. Xerostomia symptom scale rated high (patient scored 8/10 average dryness).

- **Salivary symptoms:** Thick/ropey scant saliva, absent salivary pooling, sticky mouth, and marked thirst. No excessive salivation.

3b ASSOCIATED SYMPTOMS & FUNCTION

- **Associated oral symptoms:** Intermittent oral burning, altered taste, cracked lips, fissured tongue, recurrent oral candidiasis (twice this year), and **rapidly progressive caries** with tooth sensitivity.
- **Functional impact:** Impaired eating and speaking, disrupted sleep, difficulty with denture-free chewing, and social/quality-of-life impact (avoids long conversations, carries water constantly).

3c AGGRAVATING / RELIEVING, MEDICATION & HISTORY

- **Aggravating / relieving:** Worse with mouth breathing at night, caffeine, and dry indoor air; partial relief with frequent water, sugar-free lozenges, and a bedroom humidifier. Alcohol-based mouthwash worsens burning.
- **Medication history: Sertraline** and **oxybutynin (bladder — strongly anticholinergic)**, **loratadine PRN**, amlodipine, and atorvastatin — several xerogenic agents that **compound** but, given dry eyes + caries pattern, are unlikely to be the sole cause.
- **Medical history:** Hypothyroidism (Hashimoto's), Raynaud's phenomenon, prior 'borderline' ANA noted years ago, hypertension, and overactive bladder. No diabetes, prior H&N radiation, RAI, or chemotherapy. Post-menopausal.

3d OCULAR / SYSTEMIC DRYNESS, DENTAL & PRIOR EVALUATION

- **Ocular / systemic dryness: Dry, gritty eyes** using artificial tears 4–6×/day (under ophthalmology, abnormal Schirmer reported), dry skin, and intermittent hand arthralgia + Raynaud's — a systemic sicca picture.
- **Dental / oral history:** Escalating **cervical and root-surface caries** despite twice-daily brushing and flossing; multiple recent restorations; on OTC fluoride only; regular 3-month recalls now.
- **Prior evaluation & treatment:** Dentist initiated fluoride varnish + saliva substitutes; ophthalmology confirmed keratoconjunctivitis sicca; no prior salivary flow testing, autoimmune serology directed at Sjögren's, or minor salivary gland biopsy.

3e PERTINENT NEGATIVES

Denies persistent unilateral gland swelling, a firm salivary mass, facial weakness/numbness, unexplained weight loss, night sweats, dysphagia to solids, non-healing ulcer, or recurrent suppurative gland infection. Presentation is diffuse sicca, not a focal gland lesion.

ROS XEROSTOMIA REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Dry / sticky mouth / thick saliva:** POSITIVE — severe, persistent, nocturnal
- **Burning / altered taste / caries:** POSITIVE — burning, dysgeusia, rapid cervical/root caries
- **Dry eyes / dry skin / arthralgia:** POSITIVE — gritty eyes, dry skin, hand arthralgia, Raynaud's
- **Gland swelling / recurrent infection:** NEGATIVE —
- **Difficulty swallowing dry foods:** POSITIVE — requires liquids with all dry foods
- **Candidiasis / denture intolerance:** POSITIVE — recurrent candidiasis x2 this year
- **Mouth breathing / sleep disturbance:** POSITIVE — nocturnal mouth breathing, frequent waking
- **Systemic B-symptoms:** NEGATIVE for fever, weight

no persistent gland enlargement

loss, night sweats

- **Exposures:** Non-smoker; minimal alcohol; multiple xerogenic meds (sertraline, oxybutynin, loratadine)

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
36.7°C — afebrile

BLOOD PRESSURE
138/80 mmHg

PAIN SCORE
3/10 oral burning; caries sensitivity intermittent

WEIGHT / BMI
132 lbs / BMI 23.4 — stable

5a EXAMINATION

- **General:** Well-appearing; frequently sips water during the visit; speech slightly 'clicky' from dryness. No acute distress.
- **Extraoral:** No persistent parotid/submandibular enlargement or tenderness (no diffuse glandular swelling today); dry skin; **angular cheilitis** bilaterally; lips cracked. No cervical lymphadenopathy; cranial nerves intact.
- **Intraoral — moisture: Markedly dry, tacky mucosa; mirror sticks to the buccal mucosa; salivary pooling absent**; on gland expression only scant frothy/thick saliva obtained bilaterally (global hypofunction, not unilateral obstruction).
- **Intraoral — mucosa/tongue:** Erythematous, **depapillated (smooth) fissured tongue**; pseudomembranous candidal plaques on the palate that wipe off (candidiasis).
- **Intraoral — dental: Multiple cervical and root-surface carious lesions** at the gingival margins of several teeth (classic xerostomia caries pattern); heavy demineralization; existing restorations. Periodontal status fair.
- **Ducts:** Stensen's and Wharton's orifices patent but with **minimal, thick expressed saliva bilaterally** — consistent with generalized salivary hypofunction.

SF SALIVARY FLOW / XEROSTOMIA ASSESSMENT

6 SALIVARY FUNCTION ASSESSED

UNSTIMULATED WHOLE SALIVARY FLOW
0.05 mL/min (severely reduced; ≤0.1 mL/min meets the objective hypofunction threshold used in Sjögren's classification).

STIMULATED SALIVARY FLOW
0.4 mL/min (reduced; citric-stimulated). Low stimulated flow suggests limited residual glandular reserve.

SALIVARY POOLING
Absent — no floor-of-mouth pooling; mucosa tacky.

XEROSTOMIA SCORE

Patient-reported dryness 8/10; summated xerostomia inventory high.

CARIES / CANDIDIASIS RISK

HIGH caries risk (active cervical/root caries, severe hyposalivation); HIGH candidiasis risk (recurrent, current plaques).

DC DIAGNOSTIC CONSIDERATIONS

7 SUSPECTED CAUSE OF XEROSTOMIA

Severe objective salivary hypofunction with a systemic sicca picture — **primary Sjögren's syndrome is the leading diagnosis,** with xerogenic medication as a compounding contributor:

1. **Primary Sjögren's syndrome** — dry eyes (abnormal Schirmer) + dry mouth + objective hypofunction + arthralgia/Raynaud's + prior borderline ANA + Hashimoto's (autoimmune clustering).
2. **Medication-induced hypofunction (compounding)** — oxybutynin (anticholinergic), sertraline, loratadine amplify dryness but do not explain the ocular/autoimmune findings.
3. **Age-related salivary change** — contributory, not sufficient alone.
4. **Other** — radiation/chemo (absent), diabetes (absent), IgG4/sarcoidosis (unlikely, will screen). Amyloidosis unlikely.

DR DIAGNOSTIC RESULTS

8 REVIEWED & ORDERED STUDIES

AUTOIMMUNE SEROLOGY — ORDERED TODAY

ANA (with titer/pattern), anti-SSA/Ro and anti-SSB/La, RF, ESR/CRP, and immunoglobulins/IgG4; SPEP if indicated. Historic ANA was borderline — repeat with Sjögren's-specific antibodies.

SALIVARY FLOW TESTING — DONE TODAY

Sialometry documented (unstim 0.05, stim 0.4 mL/min) — objective severe hypofunction.

OPHTHALMOLOGY CORRELATION

Records requested from Dr. Fenn: abnormal Schirmer / ocular staining score confirming keratoconjunctivitis sicca — supports classification.

LABWORK — ORDERED

CBC, CMP, HbA1c (exclude diabetes), TSH (Hashimoto's), B12/folate/iron/ferritin (glossitis) via Dr. Persaud.

MINOR SALIVARY GLAND (LABIAL) BIOPSY

Planned/offered for focus-score confirmation if serology is equivocal — coordinated with rheumatology for classification.

MICROBIOLOGY

Palatal candidal smear positive for pseudohyphae (confirms candidiasis).

PRIOR RECORDS REVIEWED

Dental caries history & recall notes; ophthalmology sicca workup; PCP medication list (xerogenic agents identified).

A ASSESSMENT

9 XEROSTOMIA CLINICAL INTERPRETATION

Primary assessment: Severe salivary hypofunction, most consistent with primary Sjögren's syndrome (pending serology ± labial biopsy for formal classification), **compounded by anticholinergic/xerogenic medications. Confidence: HIGH for severe hypofunction; HIGH suspicion for Sjögren's.**

1. Objective severe hyposalivation (unstim 0.05 mL/min) with absent pooling.
2. Systemic sicca: keratoconjunctivitis sicca (ophthalmology), arthralgia, Raynaud's, Hashimoto's, prior borderline ANA.
3. **Oral complications:** rapidly progressive cervical/root caries, recurrent candidiasis, angular cheilitis, atrophic glossitis, burning — all driven by hyposalivation.
4. **Compounding meds:** oxybutynin/sertraline/loratadine — targets for review.
5. **No red-flag features** for lymphoma today (no persistent gland mass/organomegaly), but Sjögren's warrants long-term lymphoma awareness/surveillance.

P PLAN

10 XEROSTOMIA MANAGEMENT

1. **Confirm diagnosis:** SSA/SSB + ANA/RF + IgG4 sent; correlate ophthalmology sicca workup; **rheumatology referral** for Sjögren's classification and systemic management; labial minor salivary gland biopsy if serology equivocal.
2. **Medication review (with PCP):** de-prescribe/replace **oxybutynin** (switch to a less anticholinergic OAB agent), reassess loratadine, and evaluate sertraline necessity/alternatives to reduce xerogenic burden.
3. **Sialogogue therapy:** start **pilocarpine** (or cevimeline) given demonstrated stimulated reserve — screened for contraindications (cardiac, asthma, narrow-angle glaucoma — cleared with ophthalmology/PCP); titrate for tolerance.
4. **Symptomatic relief:** frequent water, saliva substitutes/gels, sugar-free xylitol gum/lozenges, bedside humidifier, avoid alcohol-based rinses, caffeine, and mouth-drying triggers.
5. **Aggressive caries prevention (critical): prescription high-fluoride (5000 ppm) toothpaste**, in-office fluoride varnish, custom fluoride trays, xylitol, dietary counseling, and **3-month dental recalls** with Dr. Halloran; consider non-alcoholic chlorhexidine for caries-risk control.
6. **Candidiasis treatment:** antifungal (nystatin/fluconazole per interactions) for current infection; oral hygiene and recurrence prevention while hyposalivation persists.
7. **Education & surveillance:** explained likely Sjögren's, the caries/candidiasis link, sialogogue expectations, and Sjögren's lymphoma-awareness (report any persistent gland swelling); return precautions reviewed.

F FOLLOW-UP

11 REASSESSMENT PLAN

- **Serology / lab review:** within 1–2 weeks; coordinate rheumatology appointment and biopsy decision on results.
- **Oral medicine follow-up 07/30/2026 (4 weeks):** assess pilocarpine response, dryness score, candidiasis clearance, and medication substitutions; reinforce fluoride regimen.
- **Dental:** 3-month caries-control recalls with fluoride; ophthalmology continuity for ocular sicca; long-term monitoring for salivary gland enlargement (lymphoma surveillance).

TIME DOCUMENTATION & BILLING

TOTAL TIME
60 minutes

COUNSELING / COORDINATION TIME
25 minutes (Sjögren's counseling, rheumatology & ophthalmology coordination, PCP medication-deprescribing, caries-prevention & sialogogue education)

CPT / E/M CODE(S)
99204 — New patient E/M, high complexity; sialometry documented; 87210 — candidal smear

BASIS FOR BILLING
Medical Decision Making — High; probable systemic autoimmune disease, extensive serologic workup, multidisciplinary referrals, prescription management incl. deprescribing

PRIMARY ICD-10
M35.00 — Sjögren syndrome, unspecified (suspected, pending classification)

SECONDARY ICD-10
K11.7/R68.2 Xerostomia · K02.3 Rampant dental caries (cervical/root) · B37.0 Candidal stomatitis · K14.0 Glossitis · H16.229 Keratoconjunctivitis sicca · E06.3 Hashimoto thyroiditis

PROVIDER SIGN-OFF

ORAL MEDICINE SPECIALIST	CREDENTIALS	SPECIALTY	DATE	TIME
Priya Raghunathan, DDS, MD	DDS, MD, Diplomate ABOM	Oral Medicine	07/02/2026	10:30 AM