MARVIX AI

SAMPLE SALIVARY GLAND DISORDER SOAP NOTE

RECURRENT SUBMANDIBULAR SIALOLITHIASIS
WITH ACUTE BACTERIAL SIALADENITIS

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Marcus D. Ferreira

DATE OF SERVICE
06/29/2026

DOB
07/19/1979

PROVIDER
Dr. Nathaniel Park, DDS, MD — Oral Medicine

AGE / SEX
46 / Male

CREDENTIALS
DDS, MD, Diplomate ABOM

MRN / PATIENT ID
OM-61204d

VISIT TYPE
Salivary Gland Disorder Evaluation (urgent add-on)

REFERRAL SOURCE
Self-presented / triaged from general dentist Dr. R. Nguyen for painful left jaw-angle swelling that flares at meals; two similar episodes over the past year.

DENTAL / PRIMARY CARE PROVIDER
Dentist: Dr. Rebecca Nguyen, DDS · PCP: Dr. S. Kaplan, MD

CC CHIEF COMPLAINT

2 PRIMARY SALIVARY GLAND CONCERN

> *'The left side under my jaw swells up and really hurts every time I eat — this time it hasn't gone down and now it's red and I think there's pus. I've had smaller versions of this twice before.'*

Duration: Marcus describes ~12 months of **recurrent, meal-related left submandibular swelling and pain** that previously resolved between meals. The current episode began 4 days ago and, unlike prior episodes, has **not resolved** — the swelling is now constant, warm, erythematous, and associated with a foul, salty taste and low-grade fever. This progression from intermittent obstructive symptoms to a fixed, hot, tender gland is the hallmark of **an obstructed gland that has become acutely infected.**

S SUBJECTIVE

3 PATIENT-REPORTED SALIVARY HISTORY

3a ONSET, LOCATION & SWELLING

- **Onset / course:** Recurrent x~12 months; two prior self-limited episodes (approx. 8 and 4 months ago), each with meal-triggered left submandibular swelling that settled within 1–2 hours. Current episode: 4 days, **now persistent and worsening** rather than meal-limited.

- **Location / laterality:** Left submandibular region / jaw-angle and floor of mouth; strictly **unilateral (left).** No parotid or right-sided involvement.
- **Swelling characteristics:** Firm, tender, ~3 cm, now with overlying warmth and erythema; **classically worsens within minutes of eating** (esp. sour/acidic foods) — the pathognomonic feature of ductal obstruction. Reports intermittent expression of 'gritty' salty fluid earlier in the week.

3b PAIN, SALIVARY & ASSOCIATED SYMPTOMS

- **Pain:** 4/10 at rest, spiking to 8/10 with meals; dull ache radiating to the left ear/jaw angle; relieved partially between meals in prior episodes but now near-constant.
- **Salivary symptoms:** Reduced/obstructed flow on the left, thick and at times **purulent (foul, salty) discharge**, and a sense of a 'blockage.' No generalized dry mouth. No excessive salivation.
- **Associated oral symptoms:** Foul taste, mild halitosis, mild difficulty opening fully due to pain. Denies numbness, tongue weakness, or true trismus.

3c SYSTEMIC SYMPTOMS & HISTORY

- **Systemic:** Subjective low-grade fever (measured 37.9°C at home), mild malaise; denies rigors, weight loss, night sweats, dry eyes, or joint pain (no autoimmune features).
- **Dental / oral history:** Regular dental care; no prior salivary procedures; no dentures. Reports being 'a bit dehydrated' from long work shifts.
- **Medical history:** Hypertension, mild CKD stage 2, gout, and a tendency toward dehydration; **history of a kidney stone (2019)** — relevant given shared predisposition to calculus formation. No Sjögren's, diabetes, sarcoidosis, radiation, or immunosuppression.
- **Medication / exposure history:** Amlodipine; hydrochlorothiazide (contributes to dehydration/stone risk); allopurinol; occasional ibuprofen. Non-smoker; alcohol 4–6 drinks/week; low daily water intake. No vaping/betel nut.
- **Prior evaluation & treatment:** Prior episodes managed at home with warm compresses and fluids; never imaged. No prior antibiotics, sialendoscopy, or stone removal.

3d PERTINENT NEGATIVES

Denies a rapidly enlarging painless mass, persistent hard fixed enlargement between episodes, facial weakness, facial numbness, true trismus, unexplained weight loss, night sweats, dysphagia to solids, airway compromise, or immunosuppression. No feature suggesting neoplasm or floor-of-mouth abscess with airway threat at this time.

ROS SALIVARY GLAND REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Gland swelling / pain / recurrence:** POSITIVE — recurrent left submandibular; now persistent x4 days
- **Purulent / foul discharge:** POSITIVE — foul salty discharge from left floor of mouth
- **Fever / malaise / dehydration:** POSITIVE — low-grade fever, malaise, poor hydration
- **Meal-related swelling/pain:** POSITIVE — classic postprandial swelling (obstruction)
- **Dry mouth / thick saliva:** POSITIVE for left-sided thick/obstructed saliva; NO generalized xerostomia
- **Dry eyes / arthralgia / autoimmune:** NEGATIVE — no Sjögren's features

- **Facial weakness / numbness / trismus:** NEGATIVE
- **Dysphagia / airway symptoms:** NEGATIVE — no airway threat
- **Exposures:** Non-smoker; moderate alcohol; thiazide + low water intake (stone risk)

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE	BLOOD PRESSURE
38.1°C — low-grade fever	146/90 mmHg
HEART RATE	**PAIN SCORE**
92 bpm	4/10 rest; 8/10 with meals

5a EXAMINATION

- **General:** Uncomfortable but non-toxic, well-hydrated appearance borderline; speaking and swallowing intact; no stridor or drooling.
- **Extraoral — glands/neck: Left submandibular gland enlarged (~3 cm), firm, markedly tender, warm, with overlying erythema**; no fluctuance suggesting a drainable abscess yet. Right submandibular and both parotids normal. Tender left level IB node. No skin fistula.
- **Facial nerve / cranial nerves:** Facial nerve intact (expected — submandibular, not parotid); no lingual/hypoglossal deficit; tongue midline with normal movement.
- **Intraoral — ducts: Left Wharton's duct erythematous and inflamed; expression of the gland produces scant thick purulent saliva** (cloudy, foul). A firm **palpable stone is felt along the mid-course of the left Wharton's duct** in the floor of mouth. Right Wharton's and both Stensen's ducts express clear saliva.
- **Intraoral — floor / mucosa:** Mild left floor-of-mouth swelling and tenderness along the duct; no fluctuant floor-of-mouth abscess, no elevation of the tongue, airway patent. Dentition intact; no odontogenic source.

SF SALIVARY FLOW / FUNCTIONAL ASSESSMENT

6 SALIVARY FUNCTION ASSESSED

- **Regional flow:** Left submandibular flow markedly reduced/obstructed with purulent expression; right submandibular and bilateral parotid flow normal and clear.
- **Saliva quality:** Left — thick, cloudy, purulent; elsewhere — clear.
- **Salivary pooling:** Overall pooling normal (no global hypofunction); localized obstruction on the left.
- **Provocation:** Sour stimulation (citric) reproduced left submandibular pain/swelling — confirms obstructive physiology.
- **Global dryness:** Absent — this is an obstructive/infectious problem, not xerostomia.

DC DIAGNOSTIC CONSIDERATIONS

7 SUSPECTED SALIVARY GLAND DISORDER

Findings point to **obstructive submandibular sialolithiasis complicated by acute bacterial sialadenitis.** Considerations, in order:

1. **Sialolithiasis (left Wharton's duct)** — palpable stone + postprandial swelling; submandibular gland accounts for ~80–90% of salivary stones.
2. **Acute bacterial (suppurative) sialadenitis** — superimposed infection: fever, warmth, erythema, purulent expression; favored by obstruction + dehydration.
3. **Chronic / recurrent sialadenitis** — recurrent prior episodes suggest chronic obstructive change.
4. **Neoplasm** — unlikely (episodic, meal-related, palpable stone, inflammatory signs) but excluded on imaging if the gland does not normalize.
5. **Autoimmune (Sjögren's/IgG4)** — unlikely (unilateral, no dryness/systemic features).

PP PROCEDURES PERFORMED

8 PROCEDURES THIS VISIT

- **Gland massage & duct expression** — bimanual milking of the left submandibular gland performed; expressed ~0.5 mL thick purulent saliva.
- **Salivary (duct) culture** — purulent expressate collected and sent for aerobic/anaerobic culture & sensitivities before antibiotics.
- **Duct probing (gentle):** confirmed a firm obstruction at the mid-Wharton's duct; no attempt at forceful stone extraction (acute infection — deferred to sialendoscopy).
- **Clinical photography** of the floor of mouth and duct orifice obtained for documentation and referral.
- **Consent & tolerance:** verbal consent obtained; no anesthesia required; patient tolerated the procedures well; no complications.

L LAB & DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED STUDIES

MICROBIOLOGY — SENT TODAY

Wharton's duct purulent culture (aerobic/anaerobic) + sensitivities; results 48–72 h. Empiric antibiotics started after collection.

ULTRASOUND — ORDERED STAT

Point-of-care/formal neck ultrasound ordered same-day to confirm/size the stone, assess for ductal dilation, and rule out a drainable abscess. Preferred first-line, no radiation, dehydration-friendly.

CT (IF NEEDED)

Non-contrast CT reserved if ultrasound is inconclusive or an abscess is suspected requiring drainage planning.

LABS — ORDERED

LABS — ORDERED

CBC with differential (leukocytosis expected), CMP (renal function given CKD/thiazide before antibiotics/hydration), CRP. Sjögren's labs NOT indicated (unilateral, no dryness).

PRIOR RECORDS REVIEWED

Dental records (no odontogenic source); PCP notes reconciled — HTN, CKD2, gout, thiazide use, 2019 renal calculus.

A ASSESSMENT

10 SALIVARY GLAND CLINICAL INTERPRETATION

Primary diagnosis: Left submandibular sialolithiasis with acute bacterial (suppurative) sialadenitis. Confidence: HIGH.

1. Palpable mid-Wharton's duct stone + classic postprandial swelling = **obstructive sialolithiasis.**
2. Fever, warmth, erythema, tender gland, and **purulent duct expression** = **superimposed acute bacterial sialadenitis.**
3. Recurrent prior episodes indicate an **underlying chronic obstructive process** likely to recur without stone removal.
4. Predisposing factors: **dehydration + thiazide** (reduced flow), prior renal calculus (stone diathesis).
5. **No abscess/airway threat** clinically today; ultrasound to confirm. **Low neoplasm probability**; reassess if the gland fails to normalize after resolution.

P PLAN

11 SALIVARY GLAND MANAGEMENT

1. **Empiric antibiotics** (after culture): amoxicillin-clavulanate covering oral flora incl. S. aureus/anaerobes; **renally dosed for CKD2** and coordinated with Dr. Kaplan; clindamycin if penicillin-allergic. Reassess at 48–72 h on culture/sensitivities.
2. **Aggressive conservative therapy:** vigorous **hydration**, **gland massage**, **warm compresses**, and **sialogogues (sour/sugar-free lemon drops)** to promote flow and mechanical stone movement.
3. **Analgesia / anti-inflammatory:** acetaminophen first-line given CKD/gout; limit NSAIDs (renal); short course only if needed with monitoring.
4. **Ultrasound STAT** to confirm stone size/position and exclude abscess; if abscess present → urgent incision & drainage / ENT.
5. **ENT / sialendoscopy referral** placed for **definitive stone management** once acute infection settles — sialendoscopic retrieval or transoral stone removal; gland-preserving where possible. Urgent if not improving or abscess develops.
6. **Address predisposing factors:** coordinate with PCP re: thiazide/dehydration and stone-risk counseling (fluid targets adjusted for CKD); gout/allopurinol continuity.

7. **Education & return precautions:** sialogogue/massage technique, hydration, and to return urgently for increasing swelling, high fever, floor-of-mouth swelling, drooling, voice change, or difficulty breathing/swallowing (airway/abscess warning signs).

F FOLLOW-UP

12 REASSESSMENT PLAN

- **48–72 h phone/visit:** review culture & sensitivities, ultrasound results, and clinical response; adjust antibiotics.
- **Oral medicine follow-up 07/09/2026 (~10 days):** confirm resolution of infection, reassess gland size/flow, and coordinate ENT/sialendoscopy timing for stone removal.
- **Escalation:** same-day ENT/ED if abscess, spreading infection, or any airway symptom; imaging surveillance if the gland remains enlarged after infection clears (exclude neoplasm/chronic sialadenitis).

TIME DOCUMENTATION & BILLING

TOTAL TIME
55 minutes

COUNSELING / COORDINATION TIME
20 minutes (ultrasound & ENT coordination, PCP/renal-dosing coordination, hydration/stone-risk and airway warning-sign education)

CPT / E/M CODE(S)
99214 — Established/urgent E/M, moderate-high complexity; 87070 — bacterial culture; duct expression documented

BASIS FOR BILLING
Medical Decision Making — Moderate-High; acute infection, prescription management with renal dosing, urgent imaging, specialist referral, culture

PRIMARY ICD-10
K11.5 — Sialolithiasis (calculus of salivary gland/duct)

SECONDARY ICD-10
K11.21 Acute recurrent sialoadenitis · K11.20 Sialoadenitis · R59.0 Localized enlarged lymph nodes · E86.0 Dehydration · N18.2 CKD stage 2

PROVIDER SIGN-OFF

ORAL MEDICINE SPECIALIST	CREDENTIALS	SPECIALTY	DATE	TIME
Nathaniel Park, DDS, MD	DDS, MD, Diplomate ABOM	Oral Medicine	06/29/2026	2:15 PM