1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Deborah A. Kilbride

DOB
06/22/1979

AGE / SEX
47 yrs / Female

MRN / PATIENT ID
SA-58904

DATE OF SERVICE
08/12/2026

PROVIDER
Marcus T. Lindqvist, MD

CREDENTIALS
MD, FACS — Otolaryngology

PRIMARY CARE PROVIDER
Joel Anand, MD

VISIT TYPE
Follow-Up — 22 months post-FESS, recurrent polyposis, biologic decision visit

CARE SETTING
Outpatient combined Sinus & Allergy Clinic; allergy/immunology co-visit same day

REFERRING PROVIDER
Allergy & Immunology — Priya Shah, MD

INTERPRETER USED
None required

CC CHIEF COMPLAINT

2 PRIMARY SINUS / ALLERGY CONCERN

"The polyps are back. I can't smell anything at all again, my nose is blocked on both sides, and I've been on four rounds of prednisone this year. My asthma is worse too. I don't want a third surgery."

S SUBJECTIVE

3 PATIENT-REPORTED SINONASAL & ALLERGY HISTORY

3a REASON FOR EVALUATION & SYMPTOM PROFILE

Reason for Sinus & Allergy Evaluation

Follow-up for recurrent chronic rhinosinusitis with nasal polyps 22 months after bilateral functional endoscopic sinus surgery, with complete anosmia, worsening asthma control, and four systemic corticosteroid courses in the past 12 months. Visit purpose is to review CT and endoscopy findings, confirm aspirin-exacerbated respiratory disease, and decide between biologic therapy, aspirin desensitization, and revision surgery.

Nasal Symptoms

Bilateral obstruction, roughly 80% on the right and 90% on the left, present continuously for 5 months and unresponsive to maximal topical therapy. Thick postnasal drip with clearing throughout the day. Watery rhinorrhea in the mornings. No sneezing paroxysms and minimal nasal itching — the pattern is inflammatory rather than allergic. Mouth breathing at night with new snoring reported by her husband. No epistaxis apart from minor spotting after saline rinses. No crusting.

Sinus Symptoms

Persistent bilateral mid-facial and periorbital pressure, 4/10, worse bending forward. Dull frontal headache most mornings. No purulent drainage currently. Three antibiotic-treated acute exacerbations in the past 12 months (11/2025, 02/2026, 06/2026), each with purulence, fever to 100.8 °F, and increased facial pain. Symptoms are perennial without seasonal variation. Duration well beyond 12 weeks — meets criteria for chronic rhinosinusitis.

Allergy Symptoms

Mild seasonal itchy and watery eyes in spring only, adequately controlled with olopatadine drops. No urticaria. No food-related symptoms. Denies the ear and palate itching typical of pollen-driven disease during the rest of the year. Her clinical picture is dominated by eosinophilic polyposis rather than aeroallergen-driven rhinitis, which is consistent with her testing.

Symptom Onset and Course

Nasal symptoms began in 2016 at age 37 with gradual smell loss and progressive obstruction. Adult-onset asthma diagnosed 2018. First noted a severe reaction to naproxen in 2019 (see below), which was not recognized at the time as diagnostic. FESS 09/2021 with excellent 8-month response including partial return of smell, then progressive recurrence. Revision FESS 10/2024 with complete ethmoidectomy and frontal sinusotomy — smell returned for approximately 6 months, then lost again. Current recurrence dates to 03/2026, worsening steadily.

3b TRIGGERS, INFECTIONS & LOWER AIRWAY

Triggers and Exposures

Clear worsening with NSAIDs and with alcohol, particularly red wine and beer — both classic in aspirin-exacerbated respiratory disease. Strong perfumes and cleaning-product fumes at work provoke immediate congestion and cough. No pets. No smoke exposure — never smoked and no household smokers. Home is 1998 construction, carpeted bedroom, no known mold or water damage. Works as a middle-school science teacher; classroom has chemical storage and intermittent solvent odors. No humidifier; uses a HEPA purifier in the bedroom.

Recurrent Infection History

Three acute bacterial exacerbations in 12 months, each treated with amoxicillin-clavulanate (two courses) and doxycycline (one course, after a rash on the second amoxicillin-clavulanate course — morbilliform, non-urticarial, without mucosal involvement). Four prednisone bursts in 12 months (40 mg tapers), the last in 06/2026, with dramatic but transient benefit each time including temporary return of smell — a steroid-responsive pattern typical of eosinophilic disease. Sinus culture 06/2026 grew methicillin-sensitive *Staphylococcus aureus*. No orbital or intracranial complications. No immune deficiency concerns; immunoglobulins and vaccine titers normal (below).

Asthma / Lower Airway Symptoms

Adult-onset asthma since 2018. Currently uses her albuterol rescue inhaler 4–5 times weekly (was twice monthly a year ago), with nocturnal awakening 2 nights per week and exercise limitation climbing the stairs at school. On budesonide-formoterol 160/4.5, two puffs twice daily, with good technique demonstrated today. One oral steroid course for an asthma exacerbation in 02/2026 overlapping with a sinus exacerbation. No hospitalizations, no intubation. ACT score 15 — poorly controlled. Sinus and asthma flares track together, which the patient has noticed herself.

Sense of Smell / Taste

Complete anosmia for 5 months, and functionally absent for most of the past 3 years apart from steroid-associated windows. Taste flattened; she reports food is “texture only” and has stopped cooking, which she names as the single most distressing symptom — more than the obstruction. Two safety events: failed to smell a gas leak at home (detected by her husband) and did not notice burning food. No head trauma. COVID-19 in 2022 with no additional smell change beyond her baseline loss.

3c TREATMENT, TESTING & RELEVANT HISTORY

Medication History and Response

Current: mometasone nasal spray two sprays each nostril daily (adherent, good technique verified), budesonide 0.5 mg respule added to twice-daily high-volume saline irrigation (off-label steroid irrigation, started 04/2026, modest benefit), montelukast 10 mg nightly (helpful for asthma, continued; no neuropsychiatric symptoms — specifically asked), olopatadine eye drops PRN, budesonide-formoterol inhaler, albuterol PRN. Failed or inadequate: fluticasone spray (2016–2021), oral antihistamines (no benefit, consistent with non-allergic disease), oxymetazoline (used 5 days in 03/2026 with rebound — counseled and stopped), doxycycline 3-week course as anti-inflammatory (no durable benefit). No prior biologic. No aspirin desensitization. Access is not a barrier; she has employer insurance with specialty-drug coverage requiring prior authorization.

Allergy Testing / Immunotherapy History

Skin prick testing 01/2026: positive only to timothy grass (4 mm) and oak (3 mm); negative to dust mite, cat, dog, cockroach, *Alternaria*, *Aspergillus*, ragweed, and birch. Serum specific IgE corroborated. Total IgE 148 IU/mL. No food testing indicated. No immunotherapy started — discussed at the allergy visit and deferred, since her limited grass and oak sensitization does not explain perennial polyposis and immunotherapy would not address the eosinophilic disease. No prior systemic reactions, no epinephrine autoinjector prescribed (none indicated).

ENT / Sinus Procedure History

FESS 09/2021: bilateral maxillary antrostomy, total ethmoidectomy, sphenoidotomy; pathology showed eosinophilic polyps with more than 100 eosinophils per high-power field. Revision FESS 10/2024: complete ethmoidectomy, Draf IIa frontal sinusotomy, bilateral polypectomy; pathology again eosinophil-rich, no fungal elements, no granulomas. Septoplasty at the time of the first surgery. No nasal trauma or fracture. Post-surgical anatomy is widely patent on endoscopy — the recurrence is mucosal disease, not surgical failure.

Relevant Medical History

Adult-onset asthma (2018). **Naproxen reaction 2019:** within 45 minutes of a single 500 mg dose she developed profound nasal congestion, rhinorrhea, wheezing, and chest tightness requiring an urgent care visit and nebulized albuterol — no urticaria or angioedema. She has avoided all NSAIDs since. Together with polyposis and asthma this completes the Samter triad. No eczema or chronic urticaria. No cystic fibrosis or ciliary dyskinesia concern (normal childhood history, no bronchiectasis). Mild GERD on famotidine PRN. No sleep apnea diagnosis but new snoring. Migraine without aura, 1–2 per month. No autoimmune disease. Postmenopausal since 2024, not pregnant.

Family History

Mother: asthma and nasal polyps, underwent sinus surgery in her fifties. Father: seasonal allergic rhinitis. Sister: asthma, no polyps. No known immune deficiency, no cystic fibrosis, no aspirin sensitivity documented in relatives — though the maternal history is suggestive.

Social / Environmental History

Lives with husband in a suburban single-family home; carpeted bedroom, no pets, no smoking, no water damage. Middle-school science teacher — chemical and solvent odors are a reproducible trigger; she has already moved chemical storage out of her classroom and improved ventilation. Uses a bedroom HEPA filter. Highly motivated and health-literate; brought a printed symptom log and her prednisone dates. Able to implement environmental controls; the limiting factor is that her disease is not primarily allergen-driven.

Pertinent Negatives

Denies severe unilateral facial pain, orbital swelling, proptosis, diplopia, and vision changes. No severe headache with neurologic features, no neck stiffness, no high fever currently. No unilateral bloody drainage or unilateral mass symptoms — specifically assessed given the need to exclude neoplasm. No numbness of the cheek or teeth. No rapidly worsening symptoms. No hemoptysis, no weight loss, no night sweats.

ROS SINUS & ALLERGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Nasal symptoms	**Positive: bilateral obstruction, postnasal drip, morning rhinorrhea, mouth breathing, snoring. Negative for sneezing paroxysms, epistaxis, crusting, unilateral symptoms.**
Sinus symptoms	**Positive: bilateral facial pressure 4/10, morning frontal headache, 3 antibiotic-treated exacerbations, fatigue. Negative for current purulence, fever, dental pain, orbital symptoms.**
Smell, polyps, sleep	**Positive: complete anosmia 5 months, flattened taste, visible polyps, new snoring, two smell-related safety events. Negative for taste distortion of the parosmia type.**
Allergic symptoms	**Positive: mild spring ocular itching controlled with drops. Negative for perennial ocular symptoms, throat or ear itching, and food reactions.**
Lower airway	**Positive: rescue inhaler 4–5×/week, 2 nocturnal awakenings/week, stair-climbing limitation, ACT 15. Negative for hemoptysis and hospitalization.**
Skin and drug reactions	**Positive: NSAID respiratory reaction 2019, morbilliform rash on amoxicillin-clavulanate. Negative for urticaria, angioedema, eczema, dermatographism.**
Medication issues	**Positive: 4 prednisone bursts in 12 months, prior oxymetazoline rebound. Negative for adherence problems and for nasal spray irritation with current technique.**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE **98.4 °F**	BLOOD PRESSURE **126/78 mmHg**
HEART RATE **78 bpm**	RESPIRATORY RATE **16/min**
OXYGEN SATURATION **97% on room air**	HEIGHT **5′ 6″ (168 cm)**
WEIGHT **168 lb (76.2 kg)**	BMI **27.1 kg/m²**
PAIN SCORE **4/10 facial pressure**	

5a FOCUSED EXAMINATION

General Appearance

Alert, comfortable, no acute distress. Hyponasal voice quality. Obligate mouth breathing noted during the interview. No allergic facies or Dennie-Morgan lines. Normal work of breathing at rest; no accessory muscle use.

Eyes

Conjunctivae clear without injection or chemosis today. No tearing. No allergic shiners. No eyelid or periorbital edema. No proptosis. Extraocular movements full and painless, pupils equal and reactive, visual acuity grossly intact — specifically documented given proximity of disease to the orbit.

Ears

External ears normal. Canals patent without cerumen impaction. Tympanic membranes intact and mobile bilaterally, no effusion, no retraction. Weber and Rinne not indicated. No pressure-related findings. Hearing grossly intact to conversational voice.

Nose / Anterior Rhinoscopy

Nasal dorsum normal without widening. Septum midline post-septoplasty with no perforation. Diffuse pale, edematous, polypoid mucosa filling both middle meati and extending to the level of the inferior turbinate on the left. Grade 3 polyps on the left, grade 2 on the right. Clear to slightly mucoid secretions, no frank purulence. No crusting, no active bleeding source. Nasal valve competent. Airflow markedly reduced bilaterally, left worse than right.

Sinuses / Face

Mild tenderness to palpation over both maxillary sinuses and the left frontal region. No facial swelling, asymmetry, or erythema. No dental tenderness on percussion. No cheek or upper-lip numbness. Orbits soft, no periorbital induration.

Mouth / Throat

Oral mucosa moist and intact, no candidiasis despite inhaled and topical steroids. Tonsils 1+, no exudate. Posterior pharyngeal cobblestoning with visible clear postnasal drainage. Uvula midline, palate intact and mobile. Dentition well maintained. Dry lips consistent with mouth breathing.

Neck

No cervical, submandibular, or supraclavicular lymphadenopathy. No masses. Thyroid non-enlarged, no nodules. Full range of motion without meningismus.

Pulmonary

Normal effort at rest. Scattered end-expiratory wheezes in both lower lung fields, no crackles. Expiratory phase mildly prolonged. Dry cough elicited with forced expiration. Room air, saturation 97%. Inhaler technique observed and correct with a spacer.

Skin

No eczema, urticaria, or dermatographism. No residual rash from the 02/2026 amoxicillin-clavulanate reaction. No injection-site findings. No purpura or ecchymoses despite repeated steroid courses.

NE NASAL ENDOSCOPY

6 PROCEDURAL FINDINGS — PERFORMED THIS VISIT

Indication, consent, anesthesia, tolerance

Indication: assessment of recurrent polyposis and post-surgical cavity 22 months after revision FESS, and evaluation for biologic candidacy. Verbal consent obtained after discussion of discomfort and minor bleeding risk. Topical oxymetazoline and 4% lidocaine applied. Rigid 4 mm 0-degree endoscope, both nasal cavities. Procedure well tolerated; patient asked for a brief pause on the left, then completed.

Septum

Midline post-septoplasty. No perforation, no spur, no synechiae to the lateral wall. Mucosa intact.

Inferior and middle turbinate

Inferior turbinates mildly boggy bilaterally. Middle turbinates surgically preserved and medialized on the right, partially

resected on the left from the revision procedure. No lateralization.

Middle meatus

Widely patent antrostomies bilaterally — surgical result maintained. Both middle meati filled with pale, translucent, grape-like polyps arising from the ethmoid cavity. Right: polyps confined to the ethmoid cavity, antrostomy visible beyond them. Left: polyps prolapsing medially into the nasal cavity, obscuring the antrostomy until displaced.

Sphenoethmoid recess

Patent sphenoidotomies bilaterally. Mild polypoid change at the left sphenoethmoid recess. Thin mucus, no purulence. Frontal recesses (Draf IIa) patent bilaterally with polypoid mucosa at the margins on the left.

Polyps, edema, purulence, scarring, lesions

Diffuse bilateral eosinophilic-appearing polyposis, Lund-Kennedy endoscopic score 8 of 12 (polyps 4, discharge 2, edema 2). No purulence, no crusting, no fungal debris, no synechiae limiting access, no unilateral or friable mass, no bleeding lesion. Nasal polyp score 5 of 8 (left 3, right 2). No suspicious features requiring biopsy for neoplasm.

Culture and complications

No culture obtained — no purulence present. Post-surgical anatomy widely patent, confirming that recurrence reflects mucosal inflammatory disease rather than inadequate surgery. No complications; minimal spotting on the left, resolved with pressure before discharge.

AT ALLERGY TESTING / IMMUNOTHERAPY ASSESSMENT

7 ALLERGY EVALUATION STATUS

Type of testing	**Skin prick testing (01/2026) plus confirmatory serum specific IgE. No intradermal or patch testing indicated.**
Allergens tested and positive results	**Positive: timothy grass 4 mm, oak 3 mm. Negative: dust mite (Df/Dp), cat, dog, cockroach, *Alternaria*, *Aspergillus*, ragweed, birch, mold mix.**
Clinical relevance of sensitizations	**Limited — correlates only with her mild spring ocular symptoms. Does not explain perennial polyposis, anosmia, or asthma pattern.**
Food allergy versus intolerance	**Not applicable — no food-related symptoms; no food testing performed or indicated.**
Immunotherapy type	**None. Discussed and deferred at the allergy visit — would not address eosinophilic polyposis.**
Build-up or maintenance status	**Not applicable.**
Dose, vial, schedule, missed doses	**Not applicable.**
Local or systemic reactions	**None. Note the NSAID respiratory reaction (2019) is a pharmacologic, non-IgE reaction and is diagnostic of AERD rather than an allergy.**
Epinephrine autoinjector status	**Not prescribed — no IgE-mediated anaphylaxis risk identified.**
Symptom response and medication reduction	**No antihistamine benefit historically, consistent with non-allergic eosinophilic disease. Total IgE 148 IU/mL, absolute eosinophils 720/µL — both relevant to biologic selection.**

Environmental control counseling	**Provided: fragrance and solvent avoidance at work (already implemented), bedroom HEPA use, and strict avoidance of all NSAIDs and of alcohol during flares. Written NSAID avoidance list given, including combination OTC products.**

ST SINUS / ALLERGY ASSESSMENT TOOLS

8 VALIDATED TOOLS & INTERPRETATION

SNOT-22	**62 of 110 — severe. Prior: 71 pre-revision (09/2024), 18 at 6 months post-op (04/2025), 44 (03/2026). Trajectory documents clear relapse. Smell and taste items scored maximally.**
Total nasal symptom score	**9 of 12 — obstruction 3, rhinorrhea 2, itching 1, sneezing 0 (pattern favors inflammatory over allergic disease).**
Rhinitis control assessment test	**13 — not controlled (threshold 21).**
Asthma control test	**15 — poorly controlled (was 21 in 09/2025). Corroborates the united-airway pattern.**
Spirometry / peak flow	**FEV1 2.28 L (74% predicted), FEV1/FVC 0.71, with 14% and 320 mL improvement post-bronchodilator — reversible obstruction. FeNO 58 ppb (elevated, type 2 inflammation).**
Smell identification testing	**UPSIT 8 of 40 — anosmia. Prior: 31 of 40 at 6 months post-revision (04/2025). Objective corroboration of subjective loss.**
Nasal spray / irrigation technique	**Observed and correct. Head-down-and-forward position for irrigation reviewed and demonstrated by the patient. Adherence confirmed against pharmacy refills.**
Quality-of-life measures	**Reports stopping cooking and avoiding restaurants; two smell-related safety events. Work performance affected by fatigue and headache. Distress centered on anosmia.**

L LABORATORY AND DIAGNOSTIC RESULTS

9 RESULTS REVIEWED OR ORDERED

Allergy Testing

Skin prick and serum specific IgE as above — grass and oak only. Total IgE 148 IU/mL (08/06/2026). No food-specific IgE. Immunotherapy formulation not applicable.

Sinus Imaging

CT sinus without contrast, 08/05/2026: Lund-Mackay score 18 of 24. Near-complete bilateral ethmoid and maxillary opacification with polypoid soft tissue; sphenoid partially opacified bilaterally; frontal recesses patent with mucosal thickening. Widely patent surgical antrostomies and Draf IIa cavity confirmed. No bone erosion, no orbital or skull-base dehiscence, no expansile or unilateral mass, no calcifications suggesting fungal ball. No mucocele. Comparison to 09/2024 pre-revision CT (Lund-Mackay 20) shows recurrence approaching pre-surgical burden.

Microbiology

Endoscopically guided sinus culture 06/2026: methicillin-sensitive *Staphylococcus aureus*, sensitive to amoxicillin-clavulanate, doxycycline, and trimethoprim-sulfamethoxazole. No *Pseudomonas*, no fungal growth on culture 06/2026. No culture this visit — no purulence.

Pulmonary Testing

Spirometry today as above (FEV1 74% predicted with 14% reversibility). FeNO 58 ppb. Chest X-ray 02/2026 clear, no bronchiectasis or infiltrate. No prior chest CT — not indicated in the absence of bronchiectasis features.

Immune / Inflammatory Testing

CBC with differential 08/06/2026: WBC 8.4, absolute eosinophils 720/µL (8.6%) — elevated; prior 640/µL. Hgb 13.6, platelets normal. IgG 1,040, IgA 210, IgM 118 mg/dL (all normal). Pneumococcal and tetanus titers protective — no immune deficiency. ANCA negative (p-ANCA and c-ANCA) — important given eosinophilia, polyposis, and asthma, to exclude eosinophilic granulomatosis with polyangiitis; no neuropathy, purpura, renal involvement, or pulmonary infiltrates to support it. ESR 22, CRP 4 mg/L.

Prior Records Reviewed

Operative reports 09/2021 and 10/2024 with both pathology reports (eosinophil-rich polyps, over 100 eosinophils per HPF, no fungal elements or granulomas), allergy/immunology consultation 01/2026, primary care and urgent care records documenting the 2019 naproxen reaction and the 2026 amoxicillin-clavulanate rash, pulmonary function history 2018–2026, four prednisone courses documented in the pharmacy record, and the patient's own symptom and steroid log.

A ASSESSMENT

10 SINUS & ALLERGY CLINICAL INTERPRETATION

- **Chronic rhinosinusitis with nasal polyps, recurrent after two endoscopic sinus surgeries** — severe by every measure: SNOT-22 62, Lund-Mackay 18 of 24, Lund-Kennedy 8 of 12, nasal polyp score 5 of 8, UPSIT 8 of 40 (anosmia). Duration far exceeds 12 weeks; disease is bilateral and perennial.
- **Aspirin-exacerbated respiratory disease (Samter triad) — now formally established** on the combination of eosinophilic nasal polyposis, adult-onset asthma, and a documented 2019 respiratory reaction to naproxen (congestion, wheeze, chest tightness within 45 minutes, without urticaria or angioedema). Alcohol-induced respiratory symptoms further support the diagnosis. This reframes prognosis: AERD polyposis recurs faster and more aggressively after surgery, which explains her 8-month and 6-month remission intervals.
- **Type 2 (eosinophilic) inflammation confirmed** — absolute eosinophils 720/µL, FeNO 58 ppb, tissue eosinophilia above 100 per HPF on two pathology specimens, and dramatic but transient corticosteroid responsiveness. This is the biologic-eligible endotype.
- **Uncontrolled asthma with united-airway disease** — ACT 15, FEV1 74% predicted with 14% reversibility, rescue use 4–5×/week, nocturnal symptoms twice weekly. Sinus and asthma flares track together; treating the upper airway alone will not be sufficient.
- **Corticosteroid exposure is now the dominant iatrogenic risk** — four systemic courses in 12 months in a postmenopausal woman. Cumulative burden warrants a steroid-sparing strategy and bone health assessment; further bursts should not be the maintenance plan.
- **Differential considered and addressed:** allergic fungal rhinosinusitis (no hyperattenuating material, no bone remodeling, negative fungal culture and pathology), eosinophilic granulomatosis with polyangiitis (negative ANCA, no neuropathy, purpura, renal or pulmonary involvement), cystic fibrosis and primary ciliary dyskinesia (adult onset, no bronchiectasis, no childhood history), immune deficiency (normal immunoglobulins and protective titers), and sinonasal neoplasm (bilateral symmetric disease, no unilateral mass, no bone erosion, no epistaxis, endoscopy without friable lesion).

- **Aeroallergen sensitization is real but clinically minor** — grass and oak only, matching mild spring ocular symptoms. Immunotherapy would not address the polyposis and is appropriately deferred.
- **Recurrent bacterial exacerbations superimposed on polyposis** — three in 12 months with MSSA on culture. These are secondary to obstructed mucus clearance, not the primary problem; antibiotics have not altered the trajectory.
- **Maximal appropriate medical therapy has been delivered and has failed:** adherent topical corticosteroid with verified technique, high-volume budesonide irrigation, montelukast, saline, and trigger avoidance. Third revision surgery alone would likely reproduce the same 6–8 month cycle.
- **Conclusion:** this patient meets criteria for biologic therapy for CRSwNP with comorbid uncontrolled type 2 asthma, and is also a candidate for aspirin desensitization. Dupilumab addresses both airways simultaneously and is the preferred first step; revision surgery is held in reserve. Anosmia, the patient's primary concern, is the symptom most likely to respond to dupilumab. No red flags requiring urgent escalation.

P PLAN

11 MANAGEMENT BY PROBLEM

- **Biologic therapy — primary intervention.** Dupilumab 300 mg subcutaneously every 2 weeks initiated, with dual indication for CRSwNP and moderate-to-severe eosinophilic asthma. Prior authorization submitted today with the CT report, endoscopy score, SNOT-22, UPSIT, two operative and pathology reports, eosinophil count, FeNO, spirometry, and documentation of failed maximal medical therapy and two prior surgeries. Injection teaching scheduled with the nursing team; first dose in clinic. Counseled on expected timeline — smell often improves within 4–8 weeks, polyp size over 6–12 months — and on possible transient blood eosinophilia, injection-site reactions, conjunctivitis, and arthralgia. Reassess at 4 months with SNOT-22, UPSIT, endoscopy, and ACT; discontinue if no meaningful response by 6 months.
- **Aspirin desensitization — offered as adjunct or alternative.** Discussed in detail: performed in a monitored setting, followed by daily high-dose aspirin maintenance, with evidence for reduced polyp regrowth, lower steroid requirement, and improved smell in AERD. She would need to accept daily aspirin indefinitely and its GI and bleeding risks. Patient elected to start with dupilumab and revisit desensitization at the 4-month reassessment if response is partial. Documented as a shared decision; written information provided.
- **Topical therapy continued.** Mometasone two sprays each nostril daily, with technique re-verified today. Continue budesonide 0.5 mg respule in twice-daily high-volume saline irrigation (240 mL per side), head-down-and-forward position, distilled or boiled-and-cooled water only — irrigation safety reviewed explicitly. Continue montelukast 10 mg nightly (helpful in AERD; no neuropsychiatric symptoms, monitoring continued).
- **Systemic corticosteroid strategy.** No burst today. Reserve prednisone for exacerbations with functional compromise, at 40 mg for 5 days without taper, and target no more than one course while establishing biologic response. Cumulative-exposure risks reviewed. **DEXA ordered** given postmenopausal status plus four courses in 12 months; vitamin D and calcium intake reviewed and vitamin D3 1,000 IU daily started (level 26 ng/mL).
- **Asthma plan.** Continue budesonide-formoterol 160/4.5 two puffs twice daily; technique with spacer verified. Written asthma action plan provided and reviewed. Rescue albuterol use to be logged. Pulmonology co-management referral placed — dupilumab will be the shared agent across both airways, so a single-biologic strategy is coordinated to avoid duplicate therapy. Repeat spirometry and FeNO at 4 months. ACT at every visit.
- **Infection plan.** No antibiotic today — no purulence and no acute exacerbation. For future exacerbations: culture-directed therapy given prior MSSA, with doxycycline or trimethoprim-sulfamethoxazole preferred over amoxicillin-clavulanate because of the 02/2026 morbilliform rash (documented as a non-severe delayed reaction, not anaphylaxis, and not a penicillin-class contraindication after allergy review). Culture before empiric therapy whenever purulence is present.

- **Strict NSAID avoidance until desensitized.** Written list of NSAIDs including hidden combination OTC products (cold remedies, menstrual and migraine formulations) provided. Acetaminophen up to 3 g/day permitted; celecoxib discussed as generally tolerated in AERD but not prescribed at this time. Allergy list in the chart updated to "NSAIDs — respiratory reaction (AERD)" to prevent inadvertent administration, and the 2019 event documented in structured form. Alcohol avoidance during flares reviewed.
- **Environmental control.** Continue fragrance and solvent avoidance at work (already implemented, with chemical storage relocated and ventilation improved), bedroom HEPA filtration, and hard-surface bedroom flooring recommended. Grass and oak measures for spring only: window closure on high-pollen days, evening showering, and continued olopatadine drops. Emphasized that allergen control supports but cannot substitute for treating the eosinophilic disease.
- **Revision surgery — deferred, not excluded.** Third revision FESS with polypectomy would relieve obstruction but is expected to recur on the AERD trajectory without disease-modifying therapy. Reconsider if dupilumab fails at 6 months, if an obstructing focus persists, or if a complication develops. If undertaken, it would be paired with biologic therapy or desensitization rather than performed alone. Risks of revision surgery in a previously operated field reviewed.
- **Referrals and coordination.** Pulmonology (asthma co-management and biologic alignment), allergy/immunology (continued co-management, desensitization planning), and specialty pharmacy for dupilumab authorization and shipment. Coordination note sent today to Dr. Shah and Dr. Anand summarizing the AERD diagnosis, the CT and endoscopy findings, and the biologic plan. Sleep medicine referral held pending nasal patency improvement, since new snoring may be obstruction-related.
- **Patient education.** Explained AERD in plain terms, why polyps return after surgery in this endotype, and why biologic therapy targets the underlying inflammation rather than the anatomy. Set realistic expectations for smell recovery and reviewed the two smell-related safety events — a home gas detector and smoke alarm check were recommended, and kitchen safety practices discussed. Instructed to seek emergency care for orbital swelling, vision change, double vision, severe headache with neck stiffness or confusion, or severe breathing difficulty unresponsive to rescue inhaler, and to call the clinic for a flare with fever and purulence, unilateral bleeding, or any injection reaction.

F FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up

Return in 4 months (12/2026) for symptom reassessment, SNOT-22 and UPSIT repeat, nasal endoscopy with Lund-Kennedy and polyp scoring, ACT and spirometry with FeNO, dupilumab tolerance and injection-site review, and a decision on adding aspirin desensitization if response is partial. Nurse visit in 2 weeks for injection teaching reinforcement and second-dose observation. Telephone check at 6 weeks specifically for smell change. DEXA and vitamin D recheck before the next visit. Earlier return for a flare with fever and purulence, any orbital or visual symptom, unilateral bleeding, or asthma deterioration; emergency care for the red flags reviewed above.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT
54 minutes

COUNSELING / EDUCATION TIME
19 minutes

ENVIRONMENTAL CONTROL COUNSELING TIME
5 minutes

IMMUNOTHERAPY COUNSELING TIME
7 minutes — aspirin desensitization and immunotherapy discussion

PROCEDURE TIME
9 minutes — diagnostic nasal endoscopy

CARE COORDINATION TIME
6 minutes

RECORDS REVIEW TIME
8 minutes

E/M LEVEL
99215 — established patient, high-complexity MDM (25 minutes documented separately from the procedure)

NASAL ENDOSCOPY CODE
31231 — nasal endoscopy, diagnostic, unilateral or bilateral (modifier 25 on the E/M)

ALLERGY TESTING CODE(S)
None this visit — performed 01/2026 (95004 ×12)

IMMUNOTHERAPY CODE(S)
Not applicable — immunotherapy deferred

SPIROMETRY / PULMONARY TESTING CODE(S)
94060 — spirometry with bronchodilator; 95012 — exhaled nitric oxide

BASIS FOR BILLING
Time-based and MDM (high complexity: biologic initiation, two failed surgeries, systemic steroid burden) plus separately identifiable procedure

PRIMARY DIAGNOSIS
J33.9 — Nasal polyp, unspecified, with J32.4 chronic pansinusitis

SECONDARY DIAGNOSES
J45.51 Severe persistent asthma with exacerbation; Z91.048 NSAID (aspirin) sensitivity — AERD; R43.0 Anosmia; D72.10 Eosinophilia; Z98.890 Personal history of sinus surgery

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Marcus T. Lindqvist, MD	MD, FACS	Otolaryngology — Sinus & Allergy	08/12/2026	11:35