1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME	Emiliano J. Castellanos-Ruiz
DOB	02/17/2022
AGE / SEX	4 yrs 6 mo / Male
MRN / PATIENT ID	PE-19042
DATE OF SERVICE	08/18/2026
PROVIDER	Naomi K. Adeyemi, MD
CREDENTIALS	MD, FAAP — Pediatric Otolaryngology
PRIMARY CARE PROVIDER	Ruth Osterman, MD (pediatrics)
VISIT TYPE	Consultation — surgical evaluation for sleep-disordered breathing and chronic ear fluid
CARE SETTING	Outpatient Pediatric ENT Clinic, tertiary children's hospital
PARENT / GUARDIAN PRESENT	Mother, Daniela Ruiz — present throughout
INFORMANT / COLLATERAL SOURCE	Mother (primary); preschool teacher report and sleep video reviewed
REFERRAL SOURCE	Pediatrics — snoring with witnessed apneas, speech delay, failed hearing screen
INTERPRETER USED	Spanish medical interpreter (in person) — mother's preferred language

CC CHIEF COMPLAINT

2 PRIMARY PEDIATRIC ENT CONCERN

Mother reports, through interpreter: "He snores every night and sometimes he stops breathing and gasps. He sleeps with his mouth open and wets the bed again. His teacher says he does not answer when she calls him, and he only says a few words compared to his cousin who is the same age."

S SUBJECTIVE

3 PATIENT- AND CAREGIVER-REPORTED HISTORY

3a REASON FOR EVALUATION & EAR SYMPTOMS

Reason for Pediatric ENT Evaluation

Consultation for pediatric obstructive sleep-disordered breathing with witnessed apneas, concurrent chronic bilateral otitis media with effusion and a failed hearing screen, and expressive speech delay — assessed together for adenotonsillectomy with bilateral tympanostomy tube candidacy.

Ear Symptoms

No current otalgia and no ear pulling for approximately 5 months — the effusion is silent, which is typical and is why it went undetected until the preschool screen. No otorrhea. Mother notes he turns the television volume high and frequently says "¿qué?" when spoken to from another room. No reported balance problems, no falls, no vertigo. Six documented episodes of acute otitis media between 14 months and 3 years, each treated with amoxicillin (two courses escalated to amoxicillin-clavulanate for treatment failure). No tympanostomy tubes to date. Ear drops used once for presumed otitis externa in 2024 with resolution.

Recurrent Otitis Media / Middle Ear Effusion History

Six acute episodes in a 22-month window (4 right, 3 left, one bilateral), all before age 3. Since his last acute infection in 03/2025 he has had persistent bilateral effusion documented by pediatrics at three separate visits: 12/2025, 03/2026, and 06/2026 — establishing effusion duration well beyond 3 months and meeting the persistence criterion for tube placement. Full-time daycare since 11 months of age with eight children in his room. No household smoke exposure; grandfather smokes outdoors only. Preschool hearing screen 05/2026: **referred bilaterally**. Tympanometry at pediatrics 06/2026: flat curves bilaterally.

Hearing and Speech / Language Concerns

Mother has been concerned about hearing for about 8 months. Inconsistent response to name, particularly in noise or from behind. Newborn hearing screen **passed bilaterally** (documented, both ears, 2022) — important, as it makes congenital sensorineural loss unlikely and points to an acquired conductive cause. Expressive vocabulary estimated at 40–50 single words with only occasional two-word combinations, against an expected 400+ words and full sentences at 4.5 years. Receptive language appears comparatively stronger — follows two-step commands with gesture. Articulation notably unclear; mother understands roughly half of his speech and unfamiliar listeners much less. Bilingual household (Spanish primary, English at preschool) — discussed explicitly with mother that bilingual exposure does not cause language delay and does not account for this degree of delay. Referred for speech-language evaluation by pediatrics in 04/2026; family has not yet been able to schedule it. No IEP or 504 plan; preschool has raised concerns twice.

3b NASAL, SLEEP & THROAT SYMPTOMS

Nasal / Sinus Symptoms

Chronic bilateral nasal congestion and obligate mouth breathing, present most days for over a year and not clearly seasonal. Clear rhinorrhea most mornings. Hyponasal, muffled speech quality noted by both mother and teacher. Frequent throat clearing. No facial pain or headache. Two courses of antibiotics for presumed sinusitis in the past year (11/2025, 02/2026) with only transient improvement. No purulent drainage currently. Mother has tried saline spray inconsistently and an over-the-counter oral antihistamine with no clear benefit. No unilateral obstruction and no unilateral bleeding — specifically asked to exclude a unilateral mass or foreign body.

Sleep / Airway Symptoms

Loud snoring every night for approximately 18 months, audible from the hallway. Mother reports witnessed breathing pauses of about 8–10 seconds followed by gasping, roughly 4–5 times per night, and provided a 90-second phone video reviewed in clinic that demonstrates loud stertorous snoring, paradoxical chest movement, and a clear pause terminated by a gasp and arousal. Sleeps in a hyperextended neck position, often sitting up against pillows. Restless with frequent position changes and sweating. Wakes unrefreshed. Daytime: naps again at preschool (which he had stopped at 3), described by his teacher as "wired and unfocused" with difficulty sitting for circle time — behavior that in children reflects sleep fragmentation rather than primary hyperactivity. Morning headaches 2–3 mornings weekly (mother recognizes him rubbing his forehead and being irritable). **Secondary nocturnal enuresis** — he was dry at night for 8 months and has been wetting 4–5 nights weekly for the past year. No prior sleep study.

Throat / Tonsil Symptoms

Only two episodes of pharyngitis in the past year, one rapid-strep positive (10/2025, treated with amoxicillin) — so recurrent throat infection is *not* the surgical indication here; obstruction is. No tonsil stones. Mother reports he chews slowly, gags on meat and dry chicken, and prefers soft or pureed foods; meals take 40–50 minutes. No drooling beyond

age expectation. No trismus, no neck swelling, no history of peritonsillar abscess. Three daycare absences in the past year for febrile illness.

3c VOICE, AIRWAY, BLEEDING & NECK

Voice / Swallowing Symptoms

Voice is hyponasal and muffled rather than hoarse — consistent with adenoidal obstruction rather than laryngeal disease. No true hoarseness, no weak cry historically, no voice fatigue. Occasional wet cough after drinking thin liquids quickly, without frank choking, cyanosis, or post-feed distress. No recurrent pneumonia. No prior feeding or swallow therapy. Growth has decelerated (see vitals) which mother attributes to slow eating; both obstruction and feeding aversion are plausible contributors.

Breathing / Noisy Breathing Symptoms

Loud stertor during sleep (nasopharyngeal, not laryngeal). **No stridor** at rest or with exertion, awake or asleep — specifically assessed, as its absence argues against fixed laryngeal or subglottic pathology. No retractions or nasal flaring when awake. No cyanotic episodes. No exertional limitation on the playground per mother and teacher. Never intubated; no prior airway procedures. No history of croup requiring hospitalization.

Epistaxis / Nasal Trauma

Two brief nosebleeds in the past year, both right-sided, both after nose picking in dry winter air, each stopping within 3 minutes with pressure. No trauma. No prolonged bleeding, no bleeding from gums or with immunizations, no unexplained bruising. No anticoagulant exposure. No family bleeding disorder — asked deliberately, since adenotonsillectomy is being considered.

Neck Mass / Lymph Node Concerns

Mother has noticed small, mobile bumps in both sides of the neck for over a year, unchanged in size, painless, without overlying redness or drainage, and more prominent after colds. No fever, no weight loss, no night sweats, no fatigue out of proportion. No cat scratch exposure, no recent travel outside the United States, no known tuberculosis contact. No prior imaging or antibiotics for the nodes. This pattern is consistent with benign reactive lymphadenopathy.

3d ATOPY, DEVELOPMENT & BACKGROUND

Allergy / Atopy History

Mild atopic dermatitis in infancy, largely resolved with emollients. No asthma diagnosis, no wheezing episodes, no inhaler use. No food allergies — his food selectivity is texture-driven rather than allergic. Environmental allergy suspected clinically but never tested. No immunotherapy. Over-the-counter antihistamine trial without benefit; no intranasal corticosteroid has ever been prescribed.

Birth and Developmental History

Born at 38 weeks 2 days by spontaneous vaginal delivery, birth weight 3.2 kg. No NICU stay, never intubated. No congenital anomalies, no syndromic features, no craniofacial differences. Gross motor milestones on time — walked at 12 months, runs and climbs normally. Fine motor age-appropriate. **Speech and language delayed:** first words at 18 months (typical 12), no two-word phrases until after 3 years. Social engagement good — makes eye contact, plays interactively, shares attention, no restricted or repetitive behaviors; mother specifically reassured that his profile does not suggest autism, though a speech-language evaluation will assess formally. Fully immunized. Feeding history notable for early texture aversion and slow transition to solids.

Past ENT History

No prior ear tubes, no adenoidectomy, no tonsillectomy, no sinus or airway surgery. No hearing aids or cochlear implant. No nasal trauma requiring care. No congenital ENT conditions. No prior ENT specialist evaluation — this is his first.

Medication History and Treatment Response

Amoxicillin ×4 courses and amoxicillin-clavulanate ×2 (all for acute otitis media or presumed sinusitis) with resolution of acute symptoms but no effect on the persistent effusion. Ciprofloxacin-dexamethasone otic drops once (2024). Cetirizine 5 mg daily for approximately 6 weeks in early 2026 — no benefit. Saline nasal spray used inconsistently (mother reports he resists it and she stopped). Acetaminophen and ibuprofen PRN. **No intranasal corticosteroid trial.** No reflux or asthma medications. No known drug allergies. Medicaid coverage; no medication cost barrier, but appointment access and

transportation are real barriers.

Family / Social History

Full-time daycare from 11 months, currently preschool with 8 children in his room. Two older siblings (ages 7 and 9), both of whom had tympanostomy tubes; the 9-year-old also had an adenotonsillectomy for snoring. No indoor smoke exposure (grandfather smokes outdoors). No pets. Lives with mother, father, three children, and maternal grandmother in a two-bedroom apartment; he shares a room with both siblings. Family history: mother had a tonsillectomy as a child; father snores heavily and is untreated; no bleeding disorders; no anesthesia complications in any family member; no known familial hearing loss. Both parents work — father in construction, mother in food service on variable shifts; scheduling and transportation to appointments are documented barriers, and the family missed two prior referrals for this reason.

Pertinent Negatives

Denies severe respiratory distress, cyanosis, and apneic episodes while awake. No drooling beyond age norms, no trismus, no neck stiffness or torticollis, no mastoid swelling or postauricular tenderness, no facial weakness. No dehydration — taking fluids well. No unilateral nasal obstruction and no unilateral bloody drainage. No progressive, fixed, or supraclavicular neck mass. No weight loss (weight is static rather than falling), no night sweats, no fevers of unknown origin, no bruising or petechiae. No stridor. No rapidly worsening symptoms.

ROS PEDIATRIC ENT REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Ears	**Positive: hearing difficulty, chronic bilateral effusion, 6 prior acute infections, high TV volume, frequent “what?”. Negative for current otalgia, ear pulling, otorrhea, balance concerns, mastoid swelling.**
Nose and sinuses	**Positive: chronic bilateral congestion, obligate mouth breathing, morning rhinorrhea, hyponasal speech, 2 nosebleeds after picking. Negative for facial pain, unilateral obstruction, unilateral bleeding, purulent drainage.**
Sleep and breathing	**Positive: nightly loud snoring, 4–5 witnessed apneas with gasping, video-documented pause, restless sleep, neck hyperextension, sweating, morning headaches, daytime napping and inattention, secondary enuresis. Negative for cyanosis and awake apnea.**
Throat and tonsils	**Positive: slow eating (40–50 min meals), gagging on meat, soft-food preference. Negative for recurrent tonsillitis (only 2 episodes/year), tonsil stones, drooling, abscess history.**
Voice, cough, swallow	**Positive: hyponasal muffled voice, occasional wet cough with thin liquids. Negative for hoarseness, stridor, frank choking, aspiration events, recurrent pneumonia.**
Neck and constitutional	**Positive: small stable bilateral cervical nodes for over a year, more prominent after colds. Negative for fever, weight loss, night sweats, fixed or supraclavicular mass, TB or cat exposure.**
Allergy and skin	**Positive: infantile eczema (resolved), clinically suspected environmental allergy. Negative for asthma, wheezing, food allergy, urticaria, bruising or petechiae.**
Development and school	**Positive: expressive speech delay (40–50 words), unclear**

Development and school	Positive: expressive speech delay (40–50 words), unclear articulation, preschool concerns raised twice, teacher-reported inattention. Negative for motor delay, social communication red flags, regression.

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
98.4 °F (36.9 °C)

BLOOD PRESSURE
96/58 mmHg (pediatric cuff)

HEART RATE
102 bpm, regular

RESPIRATORY RATE
22/min, unlabored

OXYGEN SATURATION
98% on room air (awake)

HEIGHT
40.9 in (104 cm)

WEIGHT
33.1 lb (15.0 kg)

BMI
13.9 kg/m²

GROWTH PERCENTILES
Height 18th %ile (was 34th at age 3); Weight 9th %ile (was 22nd at age 3); BMI 6th %ile — downward crossing of two major percentile lines

PAIN SCORE
0/10 — FACES scale, no distress

5a AGE-APPROPRIATE EXAMINATION

General Appearance

Alert, cooperative 4-year-old, initially shy then engaged with a sticker and a toy otoscope. Interacts warmly with mother and seeks her for reassurance. Thin build. **Obligate mouth breathing throughout the visit** with an open-mouth resting posture, long midface, and dark infraorbital shadowing. Hyponasal voice. Speech consists of single words and a few two-word phrases; intelligibility to the examiner roughly 40%. No work of breathing at rest, no retractions. Well hydrated, well groomed.

Head / Face

Craniofacial structures symmetric. No dysmorphic or syndromic features. Long face with a narrow, high-arched palate and an open-mouth posture — the adenoid facies pattern associated with chronic nasal obstruction. No facial tenderness over the maxillary or frontal regions. No facial swelling or trauma. Parotid and submandibular glands normal to palpation. Facial nerve function intact and symmetric on smile, eye closure, and brow raise.

Eyes

Conjunctivae clear without injection or discharge. Bilateral infraorbital venous congestion (allergic shiners). No periorbital swelling or erythema — specifically assessed to exclude orbital extension of sinus disease. Extraocular movements full, pupils equal and reactive. Red reflex normal bilaterally.

Ears / Otoscopy

Pinnae normal, no preauricular pits or tags. Canals patent bilaterally with a small amount of soft cerumen, easily displaced for full visualization. **Right:** tympanic membrane intact, dull and amber with visible air-fluid level and a prominent

horizontal fluid meniscus; retracted with foreshortened malleus handle; markedly reduced mobility on pneumatic otoscopy. **Left:** intact, opaque grey-yellow with bubbles behind the drum, mildly retracted, immobile on pneumatic otoscopy. No perforation, no tympanostomy tubes, no granulation, no retraction pocket, and **no evidence of cholesteatoma** in either ear. No otorrhea. No mastoid tenderness, erythema, or postauricular swelling bilaterally.

Nose / Anterior Rhinoscopy

External nose normal without saddling or deviation. Septum midline, no perforation, no spur. **Inferior turbinates markedly hypertrophic bilaterally with pale, boggy, edematous mucosa** nearly abutting the septum — appearance consistent with allergic or non-allergic inflammatory rhinitis. Scant clear rhinorrhea. No purulence, no crusting. No active bleeding; a small healed anterior septal abrasion on the right corresponds to the reported nosebleeds. No foreign body. **No polyps visible** — specifically inspected (unilateral polyps or a mass in this age group would demand imaging and biopsy). Nasal airflow severely reduced bilaterally on the mirror-fog test; he could not sustain nasal breathing with the mouth closed for more than a few seconds.

Mouth / Oral Cavity

Lips slightly dry and chapped from mouth breathing. Mucosa moist and intact, no ulcers. Tongue normal in size and mobility, no ankyloglossia. **Palate high and narrow with a deep arch** — a secondary consequence of long-standing mouth breathing. Dentition age-appropriate with mild anterior crowding and an open-bite tendency; no gross caries; dental follow-up advised. **Tonsils 4+ / grade IV bilaterally, meeting in the midline ("kissing tonsils")**, symmetric, non-erythematous, without exudate, crypts, or debris. Uvula midline, elevates symmetrically. No trismus. No lesions. Well hydrated.

Oropharynx / Throat

Posterior pharyngeal wall not fully visualizable because of tonsillar apposition. Mild cobblestoning of the visible pharyngeal mucosa with clear postnasal drainage. **No tonsillar asymmetry** and no peritonsillar fullness or medial displacement — deliberately documented, since unilateral tonsillar enlargement in a child raises concern for neoplasm and would change management. Voice hyponasal. Swallowing of water observed as intact without cough at this visit. Airway visibility Mallampati IV secondary to tonsillar size — flagged for anesthesia.

Neck

Multiple small, soft, mobile, non-tender anterior cervical lymph nodes bilaterally, largest approximately 1.0 cm in the right jugulodigastric chain. No matting, no fixation, no overlying erythema, fluctuance, or drainage. **No supraclavicular or posterior triangle nodes** — specifically checked, as those locations carry higher malignancy risk. No midline neck lesion, no thyroglossal duct cyst, no branchial cleft pit or sinus. Thyroid non-palpable and normal. Submandibular and parotid glands normal. Full painless range of motion, no torticollis, no meningismus. Overall findings are those of benign reactive lymphadenopathy.

Pulmonary / Airway Observation

Awake respiratory effort normal and unlabored. Chest clear to auscultation bilaterally with good air entry, no wheeze, crackles, or transmitted upper-airway noise. **No stridor, no retractions, no nasal flaring, no grunting.** No accessory muscle use. No tracheal tug. Room air, saturation 98%. No pectus deformity. No signs of chronic cor pulmonale — no hepatomegaly, no elevated jugular venous pressure, no peripheral edema (assessed given the duration of untreated obstruction).

Neurologic

Alert and interactive, oriented to person and place at an age-appropriate level. Cranial nerves II–XII grossly intact; facial movements symmetric; palate elevates midline; tongue protrudes midline. Gait normal, runs and hops on request. No ataxia, no nystagmus, no tremor. Balance appropriate for age on single-leg stance. Development: gross and fine motor age-appropriate; **expressive language markedly delayed** with receptive language relatively preserved — a dissociation characteristic of conductive hearing loss during the language-acquisition window. Social reciprocity and joint attention intact.

Skin

Mild xerosis on the extensor forearms with faint post-inflammatory change from prior eczema; no active flare, no excoriation, no impetiginization. No urticaria. No surgical scars. No bruising, petechiae, or purpura — specifically examined before surgical planning. No cervical or periauricular skin infection. Capillary refill brisk.

PR PEDIATRIC ENT PROCEDURE / ENDOSCOPY

6 PROCEDURAL FINDINGS — PERFORMED THIS VISIT

Procedure, indication, consent

Flexible nasopharyngoscopy performed to assess adenoid size and nasopharyngeal airway in a child with obligate mouth breathing, nightly witnessed apneas, and hyponasal speech — findings required to plan adenotonsillectomy. Verbal consent obtained from mother through the interpreter after explanation of discomfort, sneezing, and minor epistaxis risk; she remained beside him and held him on her lap. Also performed: bilateral ear microscopy for detailed drum assessment.

Topical anesthesia and tolerance

Atomized 0.05% oxymetazoline and 2% lidocaine gel applied to the right nasal floor; the left side was not instrumented as adequate views were obtained. Child tolerated the procedure with brief crying at insertion, settled within 15 seconds with mother's comfort and a video distraction, and was calm and playing by the end. Total scope time under 60 seconds. No sedation used.

Ear, nasal, nasopharyngeal, laryngeal, and airway findings

Nasal cavity: hypertrophic inferior turbinates bilaterally with pale boggy mucosa; septum midline; no polyps, no mass, no foreign body. **Nasopharynx:** markedly enlarged adenoid pad obstructing an estimated 85–90% of the choanal airway, contacting the posterior aspect of the vomer and the soft palate, with no visible airway on the left choana and only a small crescent on the right. Eustachian tube orifices obscured bilaterally by adenoid tissue — the anatomic mechanism of his persistent effusions. No mass lesion, no ulceration, no asymmetric or friable tissue. **Ear microscopy:** confirmed serous effusion with air-fluid level on the right and thicker mucoid effusion with bubbles on the left; both drums intact, retracted, immobile; no retraction pocket, no keratin debris, no cholesteatoma. Larynx not examined — no stridor, hoarseness, or aspiration history to indicate it.

Adenoid size / obstruction

Adenoid-nasopharyngeal grade 4 of 4 — 85–90% choanal obstruction, with palatal contact. This alone explains the obligate mouth breathing, hyponasal voice, and eustachian tube dysfunction.

Vocal fold mobility and laryngeal findings

Not assessed — no clinical indication (no stridor, no hoarseness, no weak cry, no aspiration events). Would be pursued if voice or airway symptoms emerge post-operatively.

Specimens and complications

No culture, biopsy, or specimen obtained — no purulence and no suspicious lesion. **No complications:** trace right anterior epistaxis resolved spontaneously within 30 seconds without packing or cautery. Child discharged from the procedure comfortable and ambulatory, tolerating juice.

AU AUDIOLOGY / HEARING ASSESSMENT

7 HEARING TESTING & INTERPRETATION

Newborn hearing screen status	**Passed bilaterally (2022, documented from birth records) — makes congenital sensorineural loss unlikely and supports an acquired conductive etiology.**
Audiogram results	**Play (conditioned) audiometry today, good reliability: right air conduction 35, 40, 35, 30 dB HL at 500 Hz, 1, 2, 4 kHz (PTA 35 dB HL); left 40, 45, 40, 35 dB HL (PTA 40 dB HL). Bone conduction 5–10 dB HL bilaterally, giving a 25–35**

	dB air-bone gap in each ear — a purely conductive, mild-to-moderate bilateral loss with normal cochlear reserve. Speech awareness threshold right 35, left 40 dB HL.
Tympanometry results	**Type B (flat) tympanograms bilaterally with normal ear canal volumes (right 0.7 mL, left 0.7 mL) — confirming middle ear effusion rather than perforation or canal obstruction. Unchanged from pediatrics 06/2026.**
Otoacoustic emissions	**DPOAEs absent bilaterally — expected with middle ear effusion (the emission cannot traverse the fluid) and not indicative of cochlear pathology given normal bone conduction.**
Auditory brainstem response	**Not performed — not indicated; behavioral audiometry was reliably obtained and normal bone conduction establishes intact cochlear function.**
Speech / language impact	**Substantial. He has had an estimated 35–40 dB bilateral conductive loss through the peak language-acquisition window — consistent with hearing conversational speech as muffled and missing unstressed morphemes and quiet consonants. This is the most probable primary driver of his expressive delay and poor intelligibility, compounded by sleep fragmentation.**
Hearing aid or cochlear implant status	**None; neither indicated. The loss is conductive, surgically correctable, and expected to resolve with effusion drainage.**
School or developmental implications	**Preschool teacher reports inconsistent response and inattention; both are plausibly hearing- and sleep-related rather than behavioral. Classroom seating, teacher-facing communication, and a remote-microphone trial recommended pending surgery.**
Need for repeat testing or referral	**Repeat audiogram and tympanometry 6–8 weeks post-tube placement to confirm normalized hearing. Speech-language pathology referral placed today with expedited scheduling assistance — do not wait for surgery. Early intervention / preschool special services referral also initiated.**

SB SLEEP-DISORDERED BREATHING ASSESSMENT

8 PEDIATRIC SLEEP & AIRWAY RISK

Snoring frequency	**Every night for approximately 18 months; audible from the hallway.**
Witnessed apneas	**Yes — 4–5 per night, 8–10 seconds, terminated by gasping. Corroborated by a 90-second caregiver video reviewed in clinic showing paradoxical chest movement and an arousal-terminated pause.**
Gasps or choking during sleep	**Present, following each observed pause.**
Restless sleep	**Marked — frequent position changes, sweating, hyperextended neck, sits up against pillows.**

Mouth breathing	**Obligate, awake and asleep. Observed throughout the visit; nasal breathing not sustainable beyond a few seconds.**
Daytime sleepiness or hyperactivity	**Both — resumed napping at preschool after having stopped at age 3, and teacher describes inattention and difficulty at circle time. In children, this behavioral phenotype commonly reflects sleep fragmentation rather than primary ADHD.**
Morning headaches	**2–3 mornings weekly, with forehead rubbing and irritability recognized by mother.**
Enuresis	**Secondary nocturnal enuresis — dry for 8 months, now wetting 4–5 nights weekly for a year. A recognized and often reversible feature of pediatric obstructive sleep apnea.**
Tonsil / adenoid findings	**Tonsils 4+ bilaterally (kissing); adenoid grade 4 of 4 with 85–90% choanal obstruction on endoscopy. Combined obstruction at two levels.**
Sleep study results	**None performed. Per practice guidelines, polysomnography is not required before adenotonsillectomy in an otherwise healthy child of this age with classic symptoms, witnessed apneas, and concordant grade 4 tonsils and adenoids; proceeding to surgery without delay is appropriate, particularly given the family's access barriers and a sleep-lab wait of 4–5 months.**
Impact on behavior, growth, school, quality of life	**Substantial and multi-domain: growth deceleration crossing two percentile lines, secondary enuresis, morning headaches, preschool inattention, and impaired speech development. OSA-18 score 88 (severe impact).**
Need for study, therapy, surgery, or referral	**Adenotonsillectomy with bilateral tympanostomy tubes recommended. No preoperative polysomnography required. Sleep medicine referral reserved for post-operative persistence. Anesthesia consultation requested given young age, severe obstructive symptoms, and Mallampati IV airway.**

ST SCREENING / ASSESSMENT TOOLS

9 STANDARDIZED TOOLS & INTERPRETATION

Pediatric sleep questionnaire (PSQ-SRBD)	**0.73 (16 of 22 items positive) — well above the 0.33 threshold predictive of obstructive sleep apnea. Informant: mother, via interpreter.**
OSA-18	**88 of 126 — severe impact on quality of life. Highest subscales: sleep disturbance and caregiver concern. Baseline recorded for post-operative comparison.**
Pediatric sinus / nasal symptom score	**Nasal obstruction and mouth breathing scored maximally; facial pain scored zero — an obstructive rather than infective sinus pattern.**
Hearing questionnaire	**Caregiver-reported hearing difficulty in 7 of 10 listening**

	situations, worst in noise and from another room. Concordant with the measured 35–40 dB conductive loss.
Speech / language screening	**Estimated expressive vocabulary 40–50 single words with rare two-word combinations against 400+ words and sentences expected at 4 years 6 months; intelligibility to an unfamiliar listener under 50%. Screen failed — formal speech-language evaluation referred. Bilingual exposure documented and explicitly excluded as an explanation.**
Allergy symptom score	**Moderate perennial nasal symptoms without ocular or seasonal predominance; no prior testing. Empiric intranasal corticosteroid trial is reasonable before considering testing.**
Asthma control test	**Not applicable — no asthma diagnosis, no wheezing history.**
Quality-of-life / caregiver concern	**Mother reports she sleeps in his room to watch his breathing and has done so for months; she rates her own worry 9 of 10. Documented as a legitimate driver of urgency.**
Pain scale (age-appropriate)	**Wong-Baker FACES 0/10 at rest and during the visit; brief distress during endoscopy only. Post-operative FACES-based pain plan to be provided to the family.**

L LABORATORY AND DIAGNOSTIC RESULTS

10 RESULTS REVIEWED OR ORDERED

Audiology Testing

Play audiometry, tympanometry, and DPOAEs performed today with results as documented above — bilateral mild-to-moderate conductive loss (right PTA 35, left PTA 40 dB HL) with 25–35 dB air-bone gaps, type B tympanograms bilaterally, absent DPOAEs. Newborn hearing screen from 2022 obtained: passed bilaterally. Preschool screen 05/2026: referred bilaterally. Pediatrics tympanometry 06/2026: flat bilaterally — establishing effusion persistence across three time points.

Microbiology / Infection Testing

Rapid strep positive 10/2025 (single episode, treated). No culture obtained today — no purulence, no acute infection. Prior ear cultures: none obtained during his acute episodes. No antibiotic sensitivity data available. No viral testing indicated.

Imaging

None obtained and none indicated. CT sinus is not warranted — there is no complicated or unilateral sinus disease, and adenoid size was assessed directly by endoscopy without radiation. Lateral neck radiography is unnecessary for the same reason. Neck ultrasound not indicated for soft, mobile, stable, bilateral reactive nodes without red-flag features. No temporal bone imaging — no cholesteatoma, no retraction pocket, no sensorineural component. Documented explicitly to record that imaging was considered and deliberately deferred.

Allergy / Immune Testing

No allergy testing performed to date. **Immune workup considered and deferred:** six otitis media episodes with two mild sinus episodes in an unvaccinated-for-none, daycare-attending child is within the expected range for daycare exposure, and there is no history of pneumonia, skin abscess, sepsis, chronic diarrhea, failure to thrive from birth, or opportunistic infection. Immunoglobulins and vaccine titers would be pursued only if infections continue post-operatively. CBC to be obtained with pre-operative labs.

Sleep / Airway Testing

No polysomnography — not required in an otherwise healthy 4-year-old with classic symptoms, caregiver-witnessed apneas, video corroboration, and grade 4 tonsils and adenoids on examination. Overnight oximetry considered but would not change the surgical decision. No prior operative airway findings (surgically naive airway).

Prior Records Reviewed

Pediatrics notes 2022–2026 including all six otitis media episodes with antibiotic courses and the three documented persistent-effusion visits; birth records with the newborn hearing screen; preschool hearing screen 05/2026; immunization record (up to date); pediatrics tympanometry 06/2026; unfilled 04/2026 speech-language referral; two prior no-show referral records with the reasons documented (work schedule, transportation); the caregiver-recorded 90-second sleep video; and a written preschool teacher report describing inattention and inconsistent response to name.

A ASSESSMENT

11 PEDIATRIC ENT CLINICAL INTERPRETATION

- **Obstructive sleep-disordered breathing, clinically severe, secondary to adenotonsillar hypertrophy** — nightly snoring for 18 months, 4–5 witnessed apneas per night with video-corroborated paradoxical breathing and arousal, morning headaches, secondary enuresis, daytime napping and inattention, PSQ-SRBD 0.73, OSA-18 88. Two-level obstruction confirmed on examination: 4+ kissing tonsils and a grade 4 of 4 adenoid pad occluding 85–90% of the choanae.
- **Chronic bilateral otitis media with effusion causing mild-to-moderate conductive hearing loss** — effusion documented at three separate visits from 12/2025 to 06/2026 (well beyond 3 months), type B tympanograms, right PTA 35 and left PTA 40 dB HL with 25–35 dB air-bone gaps and normal bone conduction. Mechanism is direct: the adenoid pad obscures both eustachian tube orifices.
- **Expressive speech and language delay, most plausibly hearing-mediated** — 40–50 single words at 4 years 6 months against an expected 400+ with sentences, intelligibility under 50%, and relatively preserved receptive language. The receptive-expressive dissociation, a passed newborn screen, and a purely conductive loss sustained through the language-acquisition window together point to the effusion as the primary driver, with sleep fragmentation compounding it. Bilingual exposure explicitly considered and excluded as an explanation.
- **Growth deceleration** — height from the 34th to the 18th percentile and weight from the 22nd to the 9th between age 3 and now, crossing two major percentile lines. Both untreated obstructive sleep apnea (through disrupted nocturnal growth hormone secretion and increased work of breathing) and obstruction-related feeding difficulty (40–50 minute meals, gagging on textures) are contributing. This finding raises rather than lowers the urgency of intervention.
- **Chronic rhinitis with inferior turbinate hypertrophy**, clinically allergic and never treated with an intranasal corticosteroid. Contributes to nasal obstruction independently of the adenoid and warrants treatment in its own right, since it will not be corrected by surgery alone.
- **Differential considered and addressed:** congenital sensorineural hearing loss (excluded — passed newborn screen, normal bone conduction); cholesteatoma (excluded — no retraction pocket, keratin debris, or otorrhea on microscopy); autism spectrum disorder as the cause of the language delay (intact joint attention, eye contact, social reciprocity, and pretend play argue against it, though formal speech-language evaluation will assess); nasopharyngeal or tonsillar neoplasm (excluded — symmetric tonsils, smooth non-friable adenoid tissue, no unilateral obstruction or bleeding); malignant lymphadenopathy (excluded — soft, mobile, stable, bilateral, no supraclavicular involvement, no B symptoms); primary immune deficiency (considered and deferred — infection pattern is daycare-typical, no invasive or opportunistic infections); laryngeal or subglottic pathology (excluded — no stridor, hoarseness, or aspiration); and bleeding diathesis (no personal or family history, normal skin exam — screening labs pending).
- **No red flags requiring urgent escalation.** No awake apnea, cyanosis, respiratory distress, drooling, or stridor. No signs of cor pulmonale on examination. No fixed or supraclavicular neck mass, no B symptoms. Surgery is urgent-elective, not emergent.

- **Prior medical therapy has failed appropriately:** six antibiotic courses cleared acute infections but never the effusion (as expected — antibiotics do not resolve chronic effusion); a 6-week oral antihistamine trial gave no benefit; saline was used inconsistently. No intranasal corticosteroid has ever been tried, which is a genuine gap in the nasal management but not a reason to delay surgery for airway obstruction of this severity.
- **Conclusion:** the child meets criteria for **adenotonsillectomy with bilateral tympanostomy tube placement in a single anesthetic** — addressing the sleep-disordered breathing, the persistent effusion with documented hearing loss, and the eustachian tube obstruction together, and sparing him a second anesthetic. Speech-language evaluation should proceed in parallel and not wait for surgery. Anesthesia consultation is warranted given his age, severity of obstruction, and Mallampati IV airway. Access barriers (parental work schedules, transportation, two prior missed referrals) are a genuine clinical risk to follow-through and are addressed explicitly in the plan.

P PLAN

12 MANAGEMENT BY PROBLEM

- **Surgery — adenotonsillectomy with bilateral tympanostomy tubes, single anesthetic.** Indications, risks, benefits, and alternatives reviewed in full with mother through the interpreter, using a translated diagram and teach-back to confirm understanding. Risks discussed: post-tonsillectomy hemorrhage (primary within 24 hours, secondary at days 5–10, roughly 2–4%), dehydration from poor oral intake, post-obstructive pulmonary edema, velopharyngeal insufficiency and transient nasal-sounding speech, anesthetic risk, tube otorrhea, tube extrusion or blockage, persistent perforation (about 2%), and the possibility of recurrent effusion after tube extrusion. Alternatives explicitly offered and declined after discussion: continued observation (unacceptable given severity, growth deceleration, and hearing-mediated language delay), tubes alone (would not address the airway), and adenoidectomy alone (would not address the 4+ tonsils). Mother consented and elected to proceed. Target date within 3–4 weeks; scheduling coordinator to work directly around her shift schedule.
- **Perioperative and anesthesia planning. Anesthesia consultation requested** for age under 5, severe obstructive symptoms, and Mallampati IV airway — documented in the referral. Overnight observation planned rather than same-day discharge, given age and clinical severity (both are recognized admission criteria). Pre-operative CBC and coagulation screen ordered given two nosebleeds and planned tonsillectomy, though the bleeding history is benign. No aspirin or NSAIDs for 7 days pre-operatively; acetaminophen permitted. Clear-liquid fasting instructions and arrival time provided in Spanish. COVID and illness screening per institutional protocol.
- **Post-operative plan (provided in writing, in Spanish, and reviewed aloud).** Scheduled acetaminophen 15 mg/kg every 6 hours alternating with ibuprofen 10 mg/kg every 6 hours — ibuprofen is appropriate after tonsillectomy and is preferred over opioids; **no codeine or tramadol under any circumstance** (explicitly stated and documented). Aggressive hydration emphasized as the single most important home task, with a target volume and a written intake log. Soft diet, avoiding sharp or acidic foods; no straws. No strenuous activity, no swimming, and no air travel for 2 weeks. Expect worsening pain on days 4–7, ear-referred pain, halitosis, and white tonsillar eschar (normal, not infection). Water precautions and ear-drop technique for the tubes demonstrated with return-demonstration by mother. **Return immediately to the emergency department for any bright red bleeding from the mouth or nose, or for signs of dehydration — no wet diaper or urination for 8 hours, no tears, or lethargy.** Direct clinic phone number and after-hours line given.
- **Hearing and ear plan.** Tympanostomy tubes at surgery will resolve the conductive loss. Repeat audiogram and tympanometry 6–8 weeks post-operatively to confirm normalization — appointment to be booked before he leaves the surgical follow-up visit rather than left to the family to arrange. Interim classroom measures pending surgery: preferential seating near the teacher, teacher-facing communication, gaining his attention before speaking, and a remote-microphone trial requested through the preschool. Ototopical drops with the tubes as directed; water precautions reviewed.

- **Speech and language plan — not deferred to surgery.** Speech-language pathology referral placed today with an expedited request, and the clinic social worker will call the family to schedule (the 04/2026 referral went unfilled because of access barriers). Early intervention / preschool special education referral initiated for evaluation toward an individualized plan. Mother counseled to continue speaking Spanish at home — bilingual input is beneficial, not harmful, and switching languages would reduce his total language exposure. Expect meaningful expressive gains within 3–6 months of restored hearing, with therapy accelerating them.
- **Nasal and allergic rhinitis plan.** Start **fluticasone or mometasone nasal spray, one spray per nostril daily** — the never-tried intervention that addresses his turbinate hypertrophy independent of surgery. Correct technique (aim laterally toward the outer eye, not toward the septum) demonstrated to mother with the interpreter and returned-demonstrated. Daily saline spray before the steroid to improve delivery and tolerance, with practical tips for a resistant 4-year-old. Continue for 8–12 weeks and reassess. Cetirizine not restarted — no benefit on a prior 6-week trial. Environmental measures: dust-mite bedding covers, hot-water bedding washes, no indoor smoking (already observed), bedroom decluttering. Formal allergy testing deferred pending steroid response.
- **Growth and feeding plan.** Growth deceleration flagged to pediatrics with a copy of the plotted curves; weight and height to be rechecked at the 6-week post-operative visit and at 6 months, with catch-up growth an expected benefit of relieving obstruction. Feeding therapy referral placed for the texture aversion, prolonged mealtimes, and gagging on meat — these are unlikely to resolve from surgery alone. Nutrition counseling on calorie-dense soft foods provided for the post-operative period specifically.
- **Neck lymphadenopathy plan — observation.** Soft, mobile, stable, bilateral nodes with no B symptoms and no supraclavicular involvement: no imaging, no labs, no antibiotics. Mother counseled on what would change this — a node enlarging beyond 2 cm, becoming hard or fixed, appearing above the clavicle, or accompanied by fever, night sweats, or weight loss. Recheck at the post-operative visit.
- **Epistaxis plan.** Nasal saline gel or petrolatum to the anterior septum at bedtime, bedroom humidification in winter, nail trimming, and counseling against nose picking. Correct first-aid technique demonstrated: lean forward, pinch the soft cartilage for 10 uninterrupted minutes. No cautery indicated. Expect improvement once nasal steroid reduces mucosal inflammation. Pre-operative coagulation screen as above.
- **Referrals and care coordination.** Anesthesia (pre-operative), audiology (post-operative testing), speech-language pathology (expedited), early intervention / preschool special services, feeding therapy, and pediatrics (growth, immunization, ongoing care). Consolidated coordination note sent today to Dr. Osterman summarizing the surgical plan and the growth concern. **Access barriers addressed concretely:** social work engaged for transportation assistance and Medicaid transport benefit; appointments to be stacked on a single day where possible; interpreter flagged as required in the chart for every future encounter; surgical scheduling to accommodate the mother's variable shifts; reminder calls in Spanish. These steps are documented because two prior referrals were missed for exactly these reasons.
- **Caregiver education and safety.** Explained through the interpreter, with teach-back confirmed: how enlarged tonsils and adenoids obstruct breathing during sleep; how ear fluid muffles the speech sounds a child needs to learn language; why antibiotics did not fix the fluid; and why treating all three problems in one operation is preferable to staged procedures. Written Spanish-language materials on adenotonsillectomy recovery, tube care, and nasal spray technique provided. Reviewed when to seek emergency care (bleeding, dehydration, respiratory distress, cyanosis) and when to call the clinic (fever above 101.5 °F, ear drainage lasting more than a week, uncontrolled pain, refusal of all fluids). Mother voiced understanding and had no remaining questions; she was reassured that her instinct to seek help was correct.

F FOLLOW-UP

13 REASSESSMENT PLAN

Follow-up

Surgery within 3–4 weeks with anesthesia consultation and pre-operative labs beforehand. Post-operative visit at 3 weeks: healing check, tube position and patency, pain and hydration review, and repeat OSA-18 and PSQ-SRBD against today's

baselines. **Audiology at 6–8 weeks post-operatively** for repeat audiogram and tympanometry, booked before the family leaves the post-operative visit. Nasal steroid response reassessed at 8–12 weeks. Growth (height, weight, BMI plotted) rechecked at 6 weeks and again at 6 months for expected catch-up. Cervical nodes rechecked at the post-operative visit. Speech-language progress reviewed at 6 months with therapy under way. ENT follow-up thereafter every 6 months while tubes remain in place. Contact the clinic sooner for any bleeding, ear drainage persisting beyond one week, tube extrusion, return of snoring or witnessed apneas, or worsening nasal obstruction; emergency care for bleeding, dehydration, or respiratory distress.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

68 minutes (extended for interpreter-mediated counseling)

CAREGIVER COUNSELING TIME

29 minutes — surgical consent, post-operative care, hearing and language education

PROCEDURE TIME

11 minutes — flexible nasopharyngoscopy and bilateral ear microscopy

AUDIOLOGY / TEST REVIEW TIME

9 minutes — audiogram, tympanometry, DPOAEs, prior screens

CARE COORDINATION TIME

8 minutes — referrals, social work, surgical scheduling

RECORDS REVIEW TIME

11 minutes — pediatrics notes, birth records, school screen, sleep video, teacher report

E/M LEVEL

99205 — new patient, high-complexity medical decision making (68 minutes total time)

PROCEDURE CODE(S)

Planned surgical: 42820 — tonsillectomy with adenoidectomy, under age 12; 69436-50 — tympanostomy with tube insertion, general anesthesia, bilateral

NASAL ENDOSCOPY / LARYNGOSCOPY CODE(S)

31231 — nasal endoscopy, diagnostic (modifier 25 on the E/M). No laryngoscopy performed.

CERUMEN / FOREIGN BODY REMOVAL CODE(S)

Not billed — cerumen displaced incidentally for visualization; no separate removal service

AUDIOLOGY / TYMPANOMETRY CODE(S)

92582 — conditioning play audiometry; 92567 — tympanometry; 92588 — DPOAE, comprehensive

BASIS FOR BILLING

Time-based and high-complexity MDM (surgical decision with two-level obstruction, documented hearing loss, growth deceleration) plus separately identifiable diagnostic endoscopy

PRIMARY DIAGNOSIS

G47.33 — Obstructive sleep apnea (adult) pediatric, with J35.3 hypertrophy of tonsils with hypertrophy of adenoids

SECONDARY DIAGNOSES

H65.23 Chronic serous otitis media, bilateral; H90.3 Conductive hearing loss, bilateral; F80.1 Expressive language disorder; R62.51 Failure to thrive, child; J31.0 Chronic rhinitis; N39.44 Nocturnal enuresis; R59.0 Localized enlarged lymph nodes; R04.0 Epistaxis; Z62.898 Interpreter required / access barriers to care

SO

PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Naomi K. Adeyemi, MD	MD, FAAP — Pediatric Otolaryngology	Pediatric Otolaryngology / ENT	08/18/2026	14:26

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