Video Visit - Oct 06, 2025

with Erin Gordon at UCSF Pulmonary Faculty Practice

Notes from Care Team

A Note to Patients: Symptoms are concisely summarized to inform treatment recommendations. For reasons of privacy and brevity, this note does not attempt to capture all experiences that were discussed.

Progress Notes

Maria S at 10/6/2025 8:15 AM

1. Are you currently in the state of California for this Telehealth clinic visit? Yes

2. Do you give consent to be seen for this clinic visit using Telehealth? Yes

3. Under UCSF policy, clinic visits cannot be recorded. If you are recording this clinic visit using the WebEx software, we will be able to see the Recording button and we will end the clinic visit. Do you agree to not record this clinic visit? Yes

1. Patient has been verified knows how to use zoom and has the link for the visit.

Erin Gordon at 10/6/2025 8:15 AM

ASTHMA NEW PATIENT EVALUATION

CHIEF COMPLAINT

Stephen Gaudet is a 71 y.o. -year-old male presenting for evaluation of **asthma, bronchiectasis and bronchiolitis**. He has a complex history of asthma with frequent hospitalizations and intubations complicated by posterior glottic stenosis s/p dilation x6 (last 2021). His exacerbations are often triggered by environmental smoke, respiratory viruses, and respiratory irritants. Previously was dependent on continuous steroids with frequent hospitalizations but with benralizumab was able to taper off continuous steroids.

Last seen by Dr. Tang (allergy) on 9/10/25. Previously follow by Dr. Fahy who is now retired.

He has been on many different biologic combinations. He is currently on benralizumab alone (on since 2021 when eos were 270). Last was on Benralizumab+Tezepelumab 5/24-8/24 but had worsening exacerbations and daily symptom control.

Last intubation 1/2024

Last admission 6/30/25 for asthma/bronchiectasis flare (BIPAP). Prior to that he was hospitalizated 12/24

Last exacerbation 9/23/25 prednisone 80 mg

He also sees Dr. Nick Pakzad at John Muir pulmonary.

Sees Dr. Rosen from ENT--last seen 7/2025--stable posterior glottic stenosis.

Tried xolair without improvement.
Tried dupixent and had flu-like reasction.
Prophylactic azithromycin was not tolerated due to diarrhea.

He has had an indwelling port since 2013 at John Muir.

Review of tests:

ECHO 1/2025
1. No significant valvular abnormalities.
2. The left ventricular ejection fraction is hyperdynamic at 83% by biplane MOD.
3. Normal size right ventricle cavity with normal function.

Report last DEXA 12/23 osteopenia

Negative IGE to aspergillus and alternaria
+dust, grass, rye

HISTORY OF PRESENT ILLNESS

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Stephen Gaudet is a 71 year old male with severe asthma who presents with ongoing exacerbation and recent steroid use--near continuous since June 2025

He has been experiencing ongoing asthma exacerbations over the past four months, requiring multiple courses of prednisone. He recently completed his third cycle of prednisone, starting at 80 mg on September 23, tapering down to 30 mg before stopping. He does not benefit from doses lower than 30 mg and experiences muscle cramps at lower doses. Despite the steroid use, he continues to feel breathless, especially on exertion, and notes a significant reduction in exercise tolerance compared to the previous year.

He has been on Fasenra for three to four years but reports little subjective improvement in symptoms, although he acknowledges fewer hospitalizations. He experiences flu-like symptoms post-injection and sometimes feels his breathing worsens temporarily after the shot. He has not been intubated in almost two years.

He has been told by doctors that he may have mild bronchiectasis based on CT scan overreads, but he does not have a productive cough. **He occasionally clears his throat and coughs up small mucus plugs, particularly in the morning**. He has been on azithromycin in the past but discontinued it due to severe diarrhea. He has not been on antibiotics during his recent exacerbations as he does not exhibit signs of infection.

He experiences significant sleep disturbances, exacerbated by steroid use, and reports waking up gasping for air. He has undergone a home sleep study, which he found unreliable, and has previously used BiPAP without notable improvement. He monitors his oxygen saturation, which remains above 90%.

His exercise routine includes daily walks, although he finds it increasingly difficult due to breathlessness. He has a history of high blood pressure, which led to a stroke in his right eye earlier this year, but his blood pressure is now controlled with medication.

He has a history of posterior glottic stenosis, which is stable, and he can distinguish between symptoms caused by his upper airway and asthma. He has not required

dilation recently as it can trigger exacerbations.

His current medications include inhaled steroids and Fasenra injections. He has not been on oxygen therapy and does not have sleep apnea. He uses a rescue inhaler more than three times a day and rates his asthma as not controlled at all.

I obtained consent from the Patient or Surrogate Decision Maker, as well as from all individuals accompanying the patient, to record and utilize a transcription to assist with the creation of documentation of the visit. I also obtained consent from any others recorded during the encounter.

Asthma History

- Age of onset: childhood

Current Symptoms:

□ Wheezing yes
□ Cough no
□ Shortness of breath yes
□ Chest tightness yes
□ Sputum production no

Asthma Control Test (ACT) Score Tracking
Current Visit ACT (Date: 10/05/25)

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home? 2
   □ 1 (All the time)
   □ 2 (Most of the time)
   □ 3 (Some of the time)
   □ 4 (A little of the time)
   □ 5 (None of the time)
2. During the past 4 weeks, how often have you had shortness of breath? 1
   □ 1 (More than once/day)
   □ 2 (Once/day)
   □ 3 (3-6 times/week)
   □ 4 (1-2 times/week)
   □ 5 (Not at all)
3. During the past 4 weeks, how often did your asthma symptoms wake you up at night or earlier than usual in the morning? 1
   □ 1 (4+ nights/week)
   □ 2 (2-3 nights/week)
   □ 3 (Once a week)
   □ 4 (Once or twice)
   □ 5 (Not at all)
4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication? 1
   □ 1 (3+ times/day)
   □ 2 (1-2 times/day)
   □ 3 (2-3 times/week)
   □ 4 (≤1 time/week)
   □ 5 (Not at all)
5. How would you rate your asthma control during the past 4 weeks? 1
   □ 1 (Not controlled)
   □ 2 (Poorly controlled)
   □ 3 (Somewhat controlled)
   □ 4 (Well controlled)
   □ 5 (Completely controlled)
   Current Total ACT Score: 6 /25

Exacerbation History

- Number of OCS courses in past year: 3
- ED visits in past year: 1

- Hospitalizations in past year: 1
- Previous ICU admissions/intubations:too numerous

Symptom Triggers
□ Exercise yes
□ Upper respiratory infections yes
□ Weather changes yes-- worse in warm weather
□ Allergens (specify): yes
□ Irritants: yes

PAST MEDICAL HISTORY

Past Medical History:

Diagnosis	Date
• Adverse effect of anesthesia *pls see note under FYI or note dated 2/26/2019 - regarding pt's regiment for intubation*	
• Allergic rhinitis, cause unspecified	
• Anemia	
• Anesthesia Narrative *delirium for few hours after procedure; also awareness during surgery*	
• Arthritis	2022
• Asthma, chronic *Severe asthma*	
• Awareness under anesthesia	01/12/2017
• Bladder stones	1992,2020
• Cervical stenosis of spinal canal	06/14/2022
• [redacted]	[redacted]
• [redacted] Drug-induced delirium	
• Easy bruising	2015
• Effusion of lower leg joint	
• Hypercholesterolemia	1988
• Hyperlipidemia	
• Hypertension	1988
• Kidney stone *found on CT scan 2/4/2019*	
• Lung disease *severe asthma*	Birth
• Musculoskeletal disease	02/01/2022
• Osteopenia *Last DEXA 2008, T - 1.9 lumbar, T - 1.1 hip*	
• Other chronic nonalcoholic liver disease	
• [redacted]-induced psychotic disorder, unspecified (CMS code)	
• PTSD (post-traumatic stress disorder)	
• PTSD (post-traumatic stress disorder)	
• Sleep disorder	
• Urinary tract infection	2018
• Vision abnormalities	

Asthma-Related Conditions
□ Allergic rhinitis yes

□ Chronic rhinosinusitis no
□ Nasal polyps no
□ AERD no
□ GERD no
□ Obesity no
□ Obstructive sleep apnea no
□ Atopic dermatitis no

Other Medical Conditions

- HTN
- [redacted]
- CAD--Lipitor 40 mg, benazepril 40 mg, hydralazine 25 mg as needed, and hydrochlorothiazide 25 mg daily, ASA 81 mg a day
- HLD
- Right ICA with TIA

MEDICATIONS

Current Asthma Medications

- Benralizumab 30 mg every 8 weeks
- Trelegy 200-62.5-25mcg or 100-62.5-25 mcg 1 inhalation once daily
- Budesonide 0.5 mg/mL nebulizer twice daily
- Albuterol nebulizer every 4 hours
- Formoterol as needed - typically in the afternoon
- Prednisone as needed

Current Outpatient Medications:

• albuterol (PROVENTIL) 2.5 mg /3 mL (0.083 %) inhalation solution, Use 3 mL (2.5 mg total) by nebulization every 2 (two) hours as needed (wheezing, shortness of breath), Disp: 180 mL, Rfl: 11
• albuterol 90 mcg/actuation metered dose inhaler, Inhale 3 puffs into the lungs every 4 (four) hours as needed for Wheezing, Disp: 6 each, Rfl: 3
• atorvastatin (LIPITOR) 40 mg tablet, Take half tablets (20 mg total) by mouth daily, Disp: 45 tablet, Rfl: 0
• benazepriL (LOTENSIN) 40 mg tablet, Take 1 tablet (40 mg total) by mouth daily, Disp: 90 tablet, Rfl: 0
• benralizumab (FASENRA SUBCUT), Inject 1 Dose under the skin every 8 (eight) weeks, Disp: , Rfl:
• budesonide (PULMICORT) 0.5 mg/2 mL inhalation solution, Use 2 mL (0.5 mg total) by nebulization in the morning and 2 mL (0.5 mg total) in the evening., Disp: 120 mL, Rfl: 11
• cetirizine (ZYRTEC) 10 mg tablet, Take 1 tablet (10 mg total) by mouth daily as needed for Allergies, Disp: , Rfl:
• chlorhexidine (PERIDEX) 0.12 % solution, Use 17 mL in the mouth or throat as directed daily, Disp: , Rfl:
• COQ10, UBIQUINOL, ORAL, Take 1 capsule by mouth daily, Disp: , Rfl:
• EPINEPHrine (EPIPEN) 0.3 mg/0.3 mL injection, Inject 0.3 mL (0.3 mg total) into the muscle once as needed for Anaphylaxis for up to 1 dose Use as instructed, Disp: 2 each, Rfl: 3
• fluorometholone (FML) 0.1 % ophthalmic suspension, Place 1 drop into both eyes every morning, afternoon, evening, and before bedtime., Disp: 10 mL, Rfl: 0
• fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray, Use 1 spray in nostril(s) daily as needed for Rhinitis, Disp: 16 g, Rfl: 3
• formoterol fumarate (PERFOROMIST) 20 mcg/2 mL nebulizer solution, Use 2 mL (20 mcg total) by nebulization 2 (two) times daily as needed for Shortness of Breath or Wheezing, Disp: 60 mL, Rfl: 11
• hydrALAZINE (APRESOLINE) 25 mg tablet, Take 1 tablet (25 mg total) by mouth once as needed (Take as directed for elevated Blood pressures) for up

to 1 dose Take for elevated Blood pressures, Disp: 90 tablet, Rfl: 11
- **hydroCHLOROthiazide 12.5 mg tablet, Take 1 tablet (12.5 mg total) by mouth daily, Disp: 90 tablet, Rfl: 3**
- **[redacted]tablet, Rfl: 0**
- **LORazepam (ATIVAN) 1 mg tablet, Take 1/2 tablet (0.5 mg total) by mouth 2 (two) times daily as needed for shortness of breath or anxiety, Disp: 60 tablet, Rfl: 0**
- **MAGNESIUM GLYCINATE ORAL, Take 2 capsules by mouth daily, Disp: , Rfl:**
- **MULTIVITAMIN ORAL, Take 1 tablet by mouth in the morning., Disp: , Rfl:**
- **olopatadine (PATANOL) 0.1 % ophthalmic solution, Place 1 drop into both eyes in the morning and 1 drop in the evening., Disp: 5 mL, Rfl: 11**
- **omeprazole (PRILOSEC) 20 mg capsule, Take 1 capsule (20 mg total) by mouth daily, Disp: 90 capsule, Rfl: 3**
- **polyethylene glycol (MIRALAX) 17 gram/dose powder, Take 17 g by mouth daily May increase to twice daily if still constipated. Pt taking PRN., Disp: 595 g, Rfl: 0**
- **predniSONE (DELTASONE) 10 mg tablet, Take 1 tablet (10 mg total) by mouth in the morning and 1 tablet (10 mg total) in the evening., Disp: 90 tablet, Rfl: 3**
- **zolpidem (AMBIEN) 5 mg tablet, Take 1 tablet (5 mg total) by mouth nightly as needed for Sleep, Disp: 20 tablet, Rfl: 0**

Current Facility-Administered Medications:
- **albuterol (PROVENTIL HFA;VENTOLIN HFA) 90 mcg/actuation inhaler 4 puff, 4 puff, Inhalation, Once PRN, Monica C Tang, MD**

Medication Allergies:

[redacted]

Vaccination:
Not yet. Flu, COVID, pneumonia (anyone with asthma or >50)

[redacted]

[redacted]

- [redacted]
- Recreational drug use: never
- Occupation and occupational exposures: retired respiratory therapist
- Home environment (pets, carpeting, humidity issues): cats
- Exercise habits: walks marathons

PHYSICAL EXAMINATION
Video visit: +dyspnea no cough

DIAGNOSTIC STUDIES
Pulmonary Function Testing

	Latest Ref Rng & Units	7/7/2016 8:31 AM	9/22/2016 8:50 AM	12/1/2016 1:05 AM	7/23/2018 2:25 AM	1/10/2019 1:44 AM
PFT Results (Internal & External)						
FVC	3.70 L	2.19	2.35	2.30	2.47	2.22
FEV1	2.76 L	0.89	0.93	0.97	1.01	**0.93**
FEV1/FVC	74.84 %	40.58	39.44	42.18	40.68	**41.94**
DLCO, HGB UNADJ	27.29 mL/min/mmHg	23.88	25.60		25.79	
DLCO, HGB UNADJ %Pred (Non-GLI)	%	85	93		94	
VA (SB) %Pred	%	74	81		74	

No results found.

IGE 119
+SPT to perreneal rye

Chest imaging:
XR Chest 1 View AP
Result Date: 6/27/2025
FINDINGS/IMPRESSION: Redemonstrated left chest wall port with tip near the superior cavoatrial junction. Please note that the port reservoir is again not visualized, and may be radiolucent. Lungs clear. No pleural effusion or pneumothorax. Normal cardiac and mediastinal contours. Report dictated by: Eric Lopez, MD, signed by: Maya Vella, MD Department of Radiology and Biomedical Imaging

CTA Chest Pulmonary Embolism (CTPE)

Result Date: 6/27/2025
1. No evidence of acute pulmonary embolism to the level of the subsegmental pulmonary arterial branches. Report dictated by: Kevin Ding, MD, signed by: Brett Michael Elicker, MD Department of Radiology and Biomedical Imaging

My read of CT chest--mild bronchiectasis which has not worsened over time.

ASSESSMENT/PLAN:

Stephen Gaudet is a 71 y.o. yo male with

1. Severe asthma
2. Bronchiectasis
3. Bronchiolitis
4. CAD
5. Posterior Glottic stenosis
6. Osteopenia
7. Port a cath

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Severe persistent asthma with frequent exacerbations
Severe persistent asthma with frequent exacerbations over the past four months. Recent exacerbations required multiple courses of prednisone, with the latest course from September 23 to October 5. Asthma control remains poor with frequent dyspnea, nocturnal symptoms, and high rescue inhaler use. Hospitalizations have decreased, possibly due to improved self-management and premedication with steroids. Fasenra (benralizumab) has been used for three to four years, possibly reducing hospitalizations. Discussed potential new treatments, including Brinsupri for bronchiectasis exacerbations and a clinical trial for a similar drug. Risks and benefits of Brinsupri include theoretical risks of gingivitis and severe infections, but clinical trials did not show these outcomes. The clinical trial offers a chance of receiving a new drug without cost, but with the possibility of being randomized to placebo.
- Prescribe Augmentin for 7 days to address potential bacterial contribution to asthma exacerbations.
- Refer to clinical trial for new asthma/COPD drug.
- Discuss Brinsupri with insurance for potential use in bronchiectasis exacerbations.

Bronchiectasis (mild, by imaging)
Mild bronchiectasis on imaging, potentially contributing to respiratory symptoms. No productive cough or significant mucus production, but occasional small mucus plugs are noted. Discussed Brinsupri, a new drug for bronchiectasis exacerbations, which blocks neutrophil activation and may reduce exacerbations. The drug is not specifically approved for asthma.

Posterior glottic stenosis
Posterior glottic stenosis is well-managed, with no recent dilations. Symptoms of breathlessness may be exacerbated by this condition, but current management is to avoid dilation unless necessary due to potential exacerbation triggers.

Sleep disturbance due to respiratory symptoms and steroid use
Significant sleep disturbance due to respiratory symptoms and steroid use, with reports of waking up gasping for air and sleep deprivation. Previous sleep study was inconclusive, and BiPAP use did not improve symptoms. No evidence of sleep apnea, and oxygen saturation remains above 90%.
- Consider overnight oximetry during exacerbations to assess for nocturnal desaturation.

Return to clinic in 8 weeks.

High risk: This visit involved high-risk medical evaluation and management of a patient with severe persistent asthma, which carries the risk of life-threatening respiratory compromise.

I am responsible for providing ongoing care to this patient for the following serious and complex condition: Severe Asthma

I spent a total of 68 non-overlapping minutes on this patient's care on the day of their visit excluding time spent related to any billed procedures. This time includes time spent with the patient as well as time spent documenting in the medical record, reviewing patient's records and tests, obtaining history, placing orders, communicating with other healthcare professionals, counseling the patient, family, or caregiver, and/or care coordination for the diagnoses above.