Metropolitan General Hospital – Discharge Summary

PATIENT: Bellweather, Sandra Dee 1961-08-06
MRN: SYN049

ADMITTING PHYSICIAN: Dr. Sharma (Hospital Medicine)
CONSULTING PHYSICIANS: Dr. Reed (Medical Oncology), Palliative Care Service

DATE OF ADMISSION: October 5, 2022
DATE OF DISCHARGE: October 11, 2022 (To Inpatient Hospice Facility)

ADMISSION DIAGNOSES:

1. Worsening Abdominal Pain & Nausea
2. Failure to Thrive
3. Metastatic Lung Adenocarcinoma with known KRAS G12C mutation, status post progression on multiple lines of therapy.

DISCHARGE DIAGNOSES:

1. **Primary:** Terminal Stage IV Lung Adenocarcinoma (KRAS G12C Positive).
2. **Secondary:**
    - Progressive bilateral adrenal metastases causing intractable flank/abdominal pain.
    - Suspected early small bowel obstruction vs. ileus secondary to opioid use / tumor burden.
    - Cancer Cachexia / Malnutrition.
    - Refractory Nausea.
    - Anxiety / Depressed Mood related to prognosis.
    - Type 2 Diabetes Mellitus (poorly controlled in setting of illness/steroids).
    - Hypertension.

PERTINENT ONCOLOGIC HISTORY:

- Diagnosed Stage IV Lung Adenocarcinoma July 15, 2021. Presented with fatigue, incidental finding of bilateral large adrenal masses (R 7cm, L 6cm) on abdominal CT for unrelated reason. PET/CT confirmed hypermetabolic adrenal lesions, likely mets, and identified 2cm RML primary lung nodule. Brain MRI negative.
- Biopsy (Adrenal): Metastatic Adenocarcinoma, TTF-1+. NGS identified **KRAS G12C mutation**. PD-L1 IHC (22C3): **TPS 70%, CPS 75, IC Score 3/+**.
- **First-Line (Aug 2021 - July 2022):** Given high PD-L1, initiated **Pembrolizumab 200 mg IV q3 weeks** starting Aug 6, 2021. Achieved partial response (significant shrinkage of adrenal mets) and good clinical benefit for approx. **11 months**.
- **Progression (July 2022):** Scans showed regrowth of adrenal masses and new small hepatic lesions. Pembrolizumab discontinued.
- **Second-Line (July 2022 - Sept 2022):** Started targeted therapy with **Sotorasib 960 mg PO Daily** (KRAS G12C Inhibitor). Tolerated reasonably well (mild GI upset) but

repeat scans after 2 months showed minimal response / **further progression** in adrenals and liver. Sotorasib discontinued.
- **Third-Line Attempt (Sept 2022):** Brief discussion of chemotherapy (e.g., Docetaxel) but patient very hesitant due to potential side effects and declining performance status (ECOG 2-3). Received palliative radiation consult for adrenal masses but deemed poor target due to size/bilaterality. Opted for best supportive care focus.

HOSPITAL COURSE (Oct 5 - Oct 11, 2022):
Admitted from home due to intractable nausea, vomiting, severe bilateral flank/abdominal pain, poor PO intake, and increasing weakness over 1-2 weeks. Pain poorly controlled on home regimen of Hydrocodone/APAP PRN.

- **Evaluation:** Cachectic, appeared uncomfortable. Vitals stable initially. Abdomen distended, diffusely tender, hypoactive bowel sounds. Labs showed Hgb 10.1, elevated glucose (~250s), Cr 1.0, mild LFT elevation. CT Abdomen/Pelvis showed further significant enlargement of bilateral adrenal masses encasing nearby structures, stable small liver lesions, dilated loops of small bowel without clear transition point (concerning for ileus vs low-grade obstruction), possible mild peritoneal enhancement.
- **Management:**
    - Made NPO initially, started IV fluids.
    - Pain Management: Transitioned from ineffective PO PRNs to scheduled IV Hydromorphone via PCA, requiring significant titration for adequate control. Palliative care consulted, recommended adding adjuvant neuropathic agent (trial of Gabapentin started, limited by sedation). Consideration given to celiac plexus block but deemed too high risk/unlikely beneficial given location/extent of adrenal disease.
    - Nausea/Vomiting: Aggressive anti-emetic regimen including scheduled IV Ondansetron and Haloperidol, with moderate improvement. NGT considered but deferred initially.
    - Bowel Regimen: Initiated stimulant laxatives + Miralax once tolerating sips. Minimal BM results.
    - Glucose Management: Sliding scale insulin initiated. Home oral agents held.
    - Goals of Care: Extensive discussions held with patient and family by Oncology and Palliative Care. Patient expressed understanding of terminal prognosis and wished to avoid further aggressive interventions. Priority is comfort and maximizing quality of remaining time. Agreed that prognosis was likely short (weeks). Decision made to transition to inpatient hospice care for ongoing complex symptom management not easily managed at home.
- **Transition:** Family toured local inpatient hospice facility. Arrangements made for transfer. Equivalent SC opioid and anti-emetic regimen calculated for transition.

DISCHARGE CONDITION: Stable for transfer to inpatient hospice. Pain controlled on IV PCA (5/10). Nausea improved (tolerating sips). Abdomen less distended. Patient alert but fatigued. Patient and family understand and agree with hospice plan.

DISCHARGE MEDICATIONS (Hospice to manage/reconcile):

- Hydromorphone SC infusion via CADD pump (calculated equivalent dose)
- Haloperidol (PO/SL/SC conversion planned)
- Ondansetron (PO/SL conversion planned)
- Gabapentin (to be reassessed by hospice, likely stop)
- Bowel Regimen (Senna/Miralax/Bisacodyl PRN)
- Sliding Scale Insulin PRN hyperglycemia >250
- Discontinue home HTN meds, statin.

FOLLOW UP: Patient died in hospice on October 31, 2022

_____ M.D./D.O.
Anya Sharma, MD (Hospital Medicine - Electronically Signed)