Patient Name: Brenda Smith
Medical Record Number: SYN202
Date of Birth: 1963-08-19
Admission Date: 2023-11-10
Discharge Date: 2023-11-16
Discharge To: Inpatient Hospice Unit
Attending Physicians: J. Patel, MD (Oncology); S. Lee, MD (Palliative Care)

SERVICE: Medical Oncology / Palliative Care Consult

Reason for Admission: Uncontrolled pain, nausea, vomiting, and severe fatigue in setting of advanced metastatic lung cancer. ?Adrenal insufficiency.

Brief Oncologic History:
Ms. Smith was diagnosed with Stage IV NSCLC Adenocarcinoma on 2021-07-01 at age 58. She presented with persistent flank pain. Workup revealed a left lower lobe lung nodule (2 cm) and a large (7 cm) right adrenal metastasis. No other distant disease initially. CT-guided biopsy of the adrenal mass was performed.

Histopathology/Molecular Data (Adrenal Biopsy, 2021-07-08):

- **Morphology:** Invasive Adenocarcinoma, moderately differentiated, showing glandular and acinar patterns. Tumor cells infiltrating adrenal cortical tissue.
- **Immunohistochemistry:** Positive for TTF-1, Napsin A, CK7. Negative for p40, Synaptophysin.
- **Molecular:** NGS panel identified a KRAS G12C mutation. No other actionable mutations detected.
- **PD-L1 IHC (Dako 22C3):** TPS = 70%.

Given the high PD-L1 expression, she was initiated on first-line Pembrolizumab monotherapy 200mg IV every 3 weeks, starting 2021-07-23. She had an excellent initial response with significant shrinkage of both the lung primary and the adrenal metastasis, and resolution of flank pain. She remained on Pembrolizumab with good tolerance and disease control.

Surveillance CT end of August 2022 demonstrated clear radiographic progression with regrowth of the adrenal metastasis (to 5 cm) and appearance of new small pulmonary nodules. Pembrolizumab was discontinued.

She initiated second-line therapy with the KRAS G12C inhibitor Sotorasib 960mg daily in September 2022. She experienced initial disease stabilization and modest shrinkage of the adrenal lesion. Toxicities included Grade 1-2 diarrhea and mild LFT elevation (managed with dose interruption/reduction).

In April 2023, repeat imaging showed further progression with significant enlargement of the adrenal metastasis (now 9 cm with central necrosis), progression of lung nodules, and new small hepatic metastases. Sotorasib was discontinued.

She started third-line chemotherapy with Docetaxel (60 mg/m²) and Ramucirumab (10 mg/kg) every 3 weeks in May 2023. This was poorly tolerated with significant fatigue, myelosuppression (neutropenia), and

minimal radiographic benefit after 2 cycles. Treatment was stopped in July 2023 due to toxicity and progressive disease.

Since then, she has been managed with best supportive care. Her course has been marked by accelerating decline, increasing fatigue, anorexia, weight loss, and escalating opioid requirements for flank and abdominal pain related to the large adrenal mass.

Summary of Current Hospitalization:
Admitted via ED with intractable nausea/vomiting, severe generalized weakness, postural dizziness, and poorly controlled right flank pain. Found to be hypotensive (BP 85/50), tachycardic (HR 110), and appeared dehydrated.

- Labs: Hgb 9.5, Plt 140. Na 126, K 5.3, BUN 40, Cr 1.5 (baseline 0.9). Glucose 75. Cortisol (random AM) <1 ug/dL. ACTH level elevated. TSH normal. LFTs mildly elevated (AST 80, ALT 65). Albumin 2.5.
- Management: Aggressive IV hydration. Pain managed via PCA (hydromorphone) initially, transitioned to scheduled long-acting opioid (Methadone initiated by Palliative Care) plus breakthrough medication. Nausea controlled with IV haloperidol and ondansetron. Diagnosed with adrenal insufficiency likely secondary to near-total replacement of adrenal gland by tumor; started on stress-dose hydrocortisone IV, then transitioned to physiologic replacement (Hydrocortisone 20mg AM / 10mg PM PO). This led to improvement in hypotension, hyponatremia, and fatigue, although underlying cancer burden remained the primary driver of her symptoms.
- Goals of Care: Extensive discussions held with Ms. Smith and her family. She clearly articulated her wish to focus entirely on comfort and quality of remaining life, understanding her prognosis was very limited (weeks). She declined further cancer-directed therapy or invasive procedures.
- Disposition: Determined that her symptom burden and care needs exceeded what could be managed at home. Transfer to inpatient hospice unit arranged for ongoing expert symptom management and end-of-life care.

Discharge Diagnoses:

1. Progressive Stage IV NSCLC Adenocarcinoma, KRAS G12C+, PD-L1 High (s/p Pembro, Sotorasib, Docetaxel/Ram).
2. Adrenal Insufficiency secondary to metastatic involvement.
3. Uncontrolled Cancer Pain, Nausea, Fatigue (symptom crisis).
4. Hyponatremia, Hypotension (resolved with hydration/steroids).
5. Cachexia.
6. Type 2 Diabetes Mellitus (requiring minimal insulin now due to poor intake).

Discharge Condition: Serious, Guarded. Alert, oriented x3. Symptoms improved but remains weak (ECOG 4). Pain controlled on Methadone. Tolerating sips/small bites.

Medications on Transfer to Hospice:

- Methadone (per Palliative Care titration schedule)
- Hydromorphone IR (for breakthrough pain)

- Haloperidol (for nausea/agitation)
- Ondansetron ODT (for nausea)
- Hydrocortisone 20mg AM / 10mg PM PO
- Senna-S, Miralax (bowel regimen)
- Escitalopram 10mg daily (pre-existing for anxiety)

Physician Signature:

Dr. S. Lee, MD (Palliative Care)

___

Follow-up: Information that patient passed away on 2023-11-19