Discharge Summary (Final Admission)

Patient: Eastwood, Albert **MRN:** SYN113 **DOB:** 09/02/1948

Admission: 2023-05-10 | **Discharge:** 2023-05-15 (Deceased)
Physicians: Dr. A. Martin (PCP/Referring), Dr. K. Tanaka (Medical Oncology), Dr. L. Martin (Hospice/Palliative Care Inpatient), Dr. C. Ramirez (Hospital Medicine)

Discharge diagnosis: Respiratory Failure secondary to End-Stage Metastatic Lung Cancer.

1. Oncological Diagnosis

- **Primary:** NSCLC, Adenocarcinoma, Stage IVB (cT2bN2M1c), diagnosed August 2020.
- **Histology:** Adenocarcinoma (Lung Biopsy); TTF-1+.
- **Molecular:** Wild-Type (EGFR/ALK/ROS1/BRAF/KRAS etc negative).
- **PD-L1 (IHC 22C3):** TPS 15%, CPS 20, IC Score 1/+.
- **Imaging (Baseline Aug 2020):** LUL primary (4cm), mediastinal LNs, extensive bone metastases (spine, ribs, pelvis), bilateral pulmonary nodules. Brain MRI negative.
- **Recent Imaging (April 2022 - last prior to BSC):** Showed progression in lung, nodes, bone after 2 lines of therapy. No further staging imaging performed after transition to supportive care.

2. Treatment History

- **Immunotherapy/Chemotherapy:**
    - 1L: Carboplatin/Pemetrexed/Pembrolizumab (08/2020 – 09/2021)
    - 2L: Docetaxel (10/2021 – 04/2022). Stable disease ~6 mos, then progression + toxicity (neuropathy, fatigue).
- **Palliative RT:** None.
- **Bone-targeted:** Zoledronic acid (initiated Aug 2020, discontinued Apr 2022).
- **Supportive Care:** Transitioned to Best Supportive Care / Outpatient Palliative focus April 2022. Enrolled with Evergreen Home Hospice May 2022.

3. Current Admission (Terminal Care)

- **Presentation:** Admitted directly from home via hospice nurse assessment for worsening dyspnea (RR 30s, O2 sat 88% on home O2 4L), increasing lethargy, minimal PO intake, and difficulty managing oral pain medications due to drowsiness/dysphagia. Family struggling with symptom burden at home. Patient minimally responsive on arrival.
- **Workup:**
    - Focused exam consistent with end-stage malignancy: cachectic, tachypneic with accessory muscle use, coarse breath sounds bilaterally, cool extremities, obtunded.
    - Labs: Hgb 8.9, WBC 9.5, Plt 115. Cr 1.5 (baseline 1.0), BUN 55, Albumin 2.0, Calcium 10.8 (mild hypercalcemia), LFTs mildly elevated. VBG showed mild respiratory acidosis.

    - Imaging: Portable CXR showed diffuse bilateral interstitial and airspace opacities, consistent with extensive metastatic burden +/- superimposed process (infection less likely, no fever). No imaging needed to confirm terminal nature.
- **Treatment:**
    - **Goals of Care:** Confirmed DNR/DNI status and comfort-focused goals with family upon arrival. Admitted to inpatient hospice bed / General Inpatient (GIP) level of care.
    - **Respiratory Distress:** Transitioned from home O2 NC to High-Flow Nasal Cannula initially for improved comfort/humidification, then simplified to O2 mask / NC only as patient became less responsive. **Morphine sulfate continuous IV infusion** initiated and titrated aggressively for tachypnea and presumed dyspnea (titrated from 1mg/hr up to 5mg/hr). Atrovent/Albuterol nebulizers provided minimal benefit, discontinued. Scopolamine patch applied for secretion management.
    - **Pain:** Previous PO opioids ineffective/difficult to administer. Managed via Morphine infusion. No signs of overt pain (grimacing, restlessness) once infusion titrated.
    - **Neurologic Status:** Remained poorly responsive throughout admission. No specific treatment for presumed encephalopathy initiated given palliative goals. Lorazepam 0.5-1mg IV PRN used infrequently for restlessness.
    - **Hypercalcemia:** Not treated aggressively given terminal prognosis and lack of significant symptoms attributable solely to calcium. IV fluids run at KVO rate for comfort/med access only.
    - **Nutrition/Hydration:** No artificial nutrition/hydration provided per GOC. Meticulous mouth care provided by nursing staff and family.
- **Outcome:** Patient continued to decline over 5 days despite aggressive symptom management. Developed worsening respiratory failure with prolonged apneic periods. Passed away peacefully with family present.

4. Comorbidities

- Coronary Artery Disease s/p PCI
- Hypertension
- Hyperlipidemia
- Peripheral Neuropathy (chemo-induced)

5. Discharge Medications

- N/A - Patient Deceased. Inpatient medications focused on comfort included Morphine IV infusion, Scopolamine patch, Lorazepam IV PRN, artificial tears, mouth care supplies.

6. Follow-up

- N/A - Patient Deceased. Bereavement support offered to family via Hospice services.

7. Patient Education

- N/A - Focus was on family education regarding dying process, symptom management, and emotional/spiritual support.

8. Lab Values (Admission May 10 → Near Death May 14/15 → N/A)

- ALT: ~45 → 55 → (Not repeated)
- AST: ~50 → 62 → (Not repeated)
- ALP: ~300 → 380 → (Not repeated)
- Total Bilirubin: 0.8 → 1.1 → (Not repeated)
- Albumin: 2.4 → 2.0 → (Not repeated)
- Hemoglobin: 9.1 → 8.9 → (Not repeated)
- Creatinine: 1.1 → 1.5 → 1.9 (day prior to death)
- Calcium: 9.8 → 10.8 → 11.2 (day prior to death)

Electronically Signed By:
Dr. L. Martin (Hospice/Palliative Care) - 2023-05-15 16:00
Dr. C. Ramirez (Hospital Medicine) - 2023-05-15 17:30
Dr. K. Tanaka (Medical Oncology - acknowledged) - 2023-05-16 09:00
