VALLEY REGIONAL MEDICAL CENTER PALLIATIVE CARE SERVICE DISCHARGE SUMMARY

Patient Name: Alfred Porter Collins [ID SYN239] Date of Birth: October 17, 1948

Admission Date: April 2, 2025 Discharge Date: April 14, 2025 Attending: Dr. Margaret Wilson

NARRATIVE SUMMARY:

Mr. Porter-Collins was a 76-year-old gentleman with metastatic non-small cell lung cancer who had exhausted all treatment options. He was admitted for end-of-life care due to progressive respiratory failure, cachexia, and generalized weakness. The patient expired peacefully on April 14, 2025, surrounded by family, after a gradual decline during the 12-day hospitalization.

The patient was initially diagnosed with metastatic NSCLC in January 2020 after presenting with persistent cough, hemoptysis, and weight loss. He was found to have a 6.2 cm right upper lobe mass with satellite lesions throughout both lungs. Biopsy confirmed poorly differentiated adenocarcinoma with no actionable mutations and low PD-L1 expression (<1%).

He received first-line carboplatin, pemetrexed, and pembrolizumab beginning February 2020 with initial partial response, but developed disease progression after 9 months. Subsequent therapies included docetaxel (4 months), gemcitabine (3 months), and vinorelbine (2 months), all with limited benefit. The patient declined further chemotherapy in January 2022 and opted for supportive care.

During this final hospitalization, care focused entirely on comfort. The patient was initially able to communicate his wishes, which aligned with his previously documented advance directives. He expressed gratitude for the opportunity to say goodbye to his family and requested minimal interventions beyond those necessary for symptom control.

The majority of his care was directed at relieving dyspnea, which was successfully managed with scheduled morphine, supplemental oxygen, and positioning. As his condition declined, the medication regimen was adjusted to ensure continued comfort, with subcutaneous administration when oral route was no longer viable.

Family was present throughout the hospitalization and participated actively in care conferences. Spiritual support was provided by the hospital chaplain at the family's request. The palliative care team offered ongoing emotional support and guidance to both patient and family through the dying process.

In the final 48 hours, the patient became progressively somnolent with periods of restlessness that responded well to medication adjustments. Terminal secretions were effectively managed with glycopyrrolate. The patient's respirations became increasingly irregular on the morning of April 14, and he died peacefully at 10:42 AM with family at bedside.

This gentleman's death represents the natural progression of advanced, treatment-refractory lung cancer. All family members expressed that they felt supported through the process, and that the patient's final wishes were honored with dignity.

SYMPTOM MANAGEMENT:

Dyspnea:

- Initial: Morphine 5mg PO q4h, oxygen 3L
- Final: Morphine 10mg SC q4h, oxygen 2L

Pain:

- Initial: Minimal (2/10), controlled with scheduled morphine
- Final: No evidence of discomfort

Anxiety:

- Initial: Intermittent, responsive to lorazepam 0.5mg SL q6h PRN
- Final: Controlled with scheduled lorazepam 0.5mg SC q6h

Terminal secretions:

- Managed with glycopyrrolate 0.2mg SC q4h PRN, positioning
- Effective with minimal audible secretions

Terminal restlessness:

- Managed with haloperidol 0.5mg SC q4h PRN
- Required only twice during final 24 hours

FAMILY SUPPORT:

The following family members were present during hospitalization:

- Wife (primary caregiver)
- Son and daughter (local)
- Brother (visited intermittently)

Family conferences were held on admission, day 5, and day 10 to discuss care plan and expected course. All family members were present for death and were given appropriate time with the patient afterwards.

Bereavement support through our hospital program has been offered and accepted by the family. Initial follow-up is scheduled for three weeks from death, with program continuation based on family needs.

DISPOSITION:

Local funeral home (Green Valley Memorial) notified per family request. Death certificate completed with immediate cause of death as respiratory failure due to metastatic non-small

cell lung cancer. Personal effects released to wife. Hospital memorial service notification with family permission.

ETHICAL CONSIDERATIONS:

This case presented no significant ethical dilemmas as the patient's wishes were clear and consistently supported by family. The patient had completed advance directives naming his wife as healthcare proxy. POLST form documenting DNR/DNI/DNH status was in effect and honored throughout hospitalization.

The patient's care represents an excellent example of appropriate end-of-life management where focus on comfort, dignity, and family support took precedence over intervention. His peaceful death amidst loved ones fulfilled his expressed wishes.

Margaret Wilson, MD Palliative Care Service April 14, 2025