Admission: 2022-07-05 | **Discharge:** 2022-07-10
Physicians: Dr. V. Wells (Medical Oncology), Dr. J. Carter (Hospital Medicine), Dr. M. Evans (Pain Management)

Discharge diagnosis: Symptomatic Progression of Metastatic Lung Cancer with Hepatic Involvement and Moderate Cancer-Related Pain.

Patient: Paul Jackson
DOB: 12/11/1959 **ID:** SYN110

1. Oncological Diagnosis

- **Primary:** NSCLC, Adenocarcinoma, Stage IVB (cT1bN0M1c), diagnosed October 2020.
- **Histology:** Metastatic Adenocarcinoma (Liver Biopsy); TTF-1+, Napsin A+.
- **Molecular: TPM3-NTRK1 fusion positive**; EGFR/ALK/ROS1/BRAF/KRAS/MET/RET wild-type.
- **PD-L1 (IHC 22C3):** TPS 5%, CPS <10, IC Score 1/+.
- **Imaging (Baseline Oct 2020):** 1.1 cm LLL nodule (suspected primary), extensive bilobar hepatic metastases (largest 5.8 cm segment VII). Brain MRI negative.
- **Recent Imaging (June 28, 2022 - prior to admission):** Isolated hepatic progression with regrowth of multiple known lesions (largest now 2.5 cm) and appearance of several new hepatic lesions (<1cm).

2. Treatment History

- **Targeted Therapy:** Entrectinib 600 mg PO daily (11/19/2020 – 07/05/2022). Achieved durable near-complete response. Discontinued on admission due to progression. PFS ~19 months.
- **Palliative RT:** None.
- **Bone-targeted:** Not applicable (no bone mets).

3. Current Admission (Symptomatic Progression)

- **Presentation:** Admitted from oncology clinic due to increasing RUQ pain (rated 7/10), worsening fatigue, and early satiety over 2 weeks, in context of known hepatic progression on recent scans.
- **Workup:**
    - Labs on admission showed mild transaminitis (AST 50, ALT 62), stable mild hypoalbuminemia (3.2 g/dL). Bilirubin normal (0.9 mg/dL). CBC stable.
    - Abdominal Ultrasound: Confirmed multiple hepatic lesions consistent with known metastases, no biliary dilation or portal vein thrombosis. Correlated with recent CT findings.
    - Pain Management Consult (Dr. Evans): Assessed pain as primarily visceral somatic due to hepatic capsule distension. Recommended optimizing scheduled opioids + adjuvant.
- **Treatment:**
    - Entrectinib discontinued.

    - Pain Management: Transitioned from PRN Tylenol/occasional Tramadol to scheduled **Oxycontin 10 mg PO BID** with **Oxycodone 5 mg PO q4h PRN** for breakthrough pain. Achieved good pain control (rated 2-3/10 at discharge). Initiated bowel regimen (Senna-S + Miralax).
    - Nutritional Support: Encouraged small, frequent meals. Patient able to tolerate improved PO intake once pain controlled.
    - Oncology Planning: Confirmed plan to start second-line chemotherapy as outpatient. Plasma ctDNA sent during admission to explore resistance mechanisms (results pending).
- **Outcome:** Patient's pain significantly improved. Tolerating PO intake. Fatigue slightly improved with pain control. Stable for discharge.

4. Comorbidities

- Hypertension (on Losartan)
- Benign Prostatic Hyperplasia (on Tamsulosin)
- GERD (on Pantoprazole)
- Entrectinib-related: Mild cognitive changes ("fog"), mild dizziness, mild weight gain (chronic, stable).

5. Discharge Medications
New:

- Oxycontin 10 mg PO BID
- Oxycodone 5 mg PO q4h PRN pain (Disp #60)
- Senna-S 8.6/50 mg 1 tab PO BID
- Polyethylene Glycol 3350 (Miralax) 1 capful PO Daily
- **Folic Acid 1 mg PO Daily (Start Now** - for planned Pemetrexed)
  Continued:
- Losartan 50 mg PO Daily
- Tamsulosin 0.4 mg PO Daily
- Pantoprazole 40 mg PO Daily
  Discontinued:
- Entrectinib 600 mg PO Daily

6. Follow-up

- **Oncology:** Dr. V. Wells in 5-7 days (Scheduled: 07/17/2022)
    - Plan to initiate C1D1 Carboplatin + Pemetrexed chemotherapy.
    - Administer first Vitamin B12 injection.
    - Review ctDNA results if available.
- **Laboratory Monitoring:** CBC, CMP prior to oncology visit/chemo start.
- **Imaging:** Restaging CT Chest/Abdomen/Pelvis after 2-4 cycles of chemotherapy.

7. Patient Education

- Opioid use, side effects (constipation, drowsiness), safe storage/disposal. Importance of bowel regimen.

- Pain management plan, when to use breakthrough medication.
- Importance of starting Folic Acid immediately.
- Signs/symptoms requiring immediate attention (uncontrolled pain, jaundice, fever >100.4F, severe nausea/vomiting).
- Chemotherapy education scheduled with oncology nurse prior to C1D1.

8. Lab Values (Baseline Oct 2020 → Pre-admission Jul 2022 → Peak/Adm Jul 2022 → Discharge Jul 2022)

- ALT: ~25 → 55 → 62 → 58 U/L
- AST: ~22 → 45 → 50 → 47 U/L
- ALP: ~80 → 110 → 115 → 112 U/L
- Total Bilirubin: 0.6 → 0.8 → 0.9 → 0.8 mg/dL
- Albumin: 3.9 → 3.2 → 3.2 → 3.3 g/dL
- Hemoglobin: 14.0 → 13.5 → 13.2 → 13.4 g/dL

Electronically Signed By:
Dr. V. Wells (Medical Oncology) - 2022-07-10 14:55
Dr. J. Carter (Hospital Medicine) - 2022-07-10 11:30
Dr. M. Evans (Pain Management) - 2022-07-09 16:00