Evergreen Community Hospital – DISCHARGE SUMMARY

NOTE FROM SISTER: Patient died on 19th of March 2024

Hospital Discharge Summary

ADMISSION DATE: 01/15/2023
DISCHARGE DATE: 01/20/2023
ADMITTING PHYSICIAN: Dr. C. Ramirez (Hospital Medicine)
CONSULTING PHYSICIANS: Dr. V. Wells (Medical Oncology), Dr. S. Green (Pulmonary Medicine)

ADMITTING DIAGNOSES:

1. Acute Hypoxic Respiratory Failure
2. Malignant Pleural Effusion, Right
3. Progression of Metastatic Lung Cancer

DISCHARGE DIAGNOSES:

1. Malignant Pleural Effusion, Right, Status Post Thoracentesis and Indwelling Pleural Catheter (IPC) Placement.
2. Acute Hypoxic Respiratory Failure (Resolved post-thoracentesis).
3. Stage IV Lung Adenocarcinoma (WT, PD-L1 Low), Status Post Progression on First and Second Line Chemotherapy.
4. Cancer Cachexia.
5. Anxiety.

PERTINENT ONCOLOGIC HISTORY:

- **Dx:** Stage IV Lung Adeno (June 28, 2021). Presented w/ persistent cough, R pleuritic pain.
- **Staging:** R malignant pleural effusion, diffuse pleural thickening/nodules. Contralateral lung nodules. No distant mets initially. Brain MRI neg.
- **Molecular/PD-L1:** WT. PD-L1 (22C3): **TPS 15%, CPS 20, IC 1/+**.
- **1L Tx:** Carbo/Pem/Pembro (July 20, 2021 – Nov 20, 2022). Achieved good PR initially (effusion resolved). Progression in Nov 2022 with worsening pleural disease, increasing lung nodules.
- **2L Tx:** Docetaxel 75 mg/m2 IV q3wks (Dec 2022 – Jan 2023). Received only **one cycle**. Experienced significant fatigue, Grade 2 mucositis, and developed acute worsening dyspnea prior to planned C2, leading to this admission.

HOSPITAL COURSE:
Patient presented to the ED with 3-4 days of rapidly worsening dyspnea at rest (baseline mild DOE), unable to speak in full sentences. Found to be hypoxic (SpO2 87% RA). Tachycardic (HR 110). Afebrile. Chest X-ray and subsequent **CT Chest (01/15/23)** revealed a large right pleural effusion causing significant right lung atelectasis and mediastinal shift,

markedly increased from prior scans (Nov 2022). Also noted progressive pulmonary metastatic disease bilaterally.

- **Management:**
  - Admitted for management of symptomatic malignant effusion and respiratory distress. Placed on O2 via HFNC initially.
  - **Thoracentesis:** Performed by Pulmonary service on HD#1 (01/16): **1.9 Liters** straw-colored fluid removed. Immediate improvement in oxygenation (weaned to 2L NC) and subjective dyspnea. Fluid cytology confirmed adenocarcinoma.
  - **Pleural Catheter:** Due to rapid re-accumulation potential in setting of known progressive pleural disease refractory to chemo, and patient preference against chemical pleurodesis, an **Indwelling Pleural Catheter (IPC / PleurX)** was placed by Interventional Radiology on HD#3 (01/18) under local anesthesia/sedation without complication. Catheter draining well post-procedure.
  - **Oncology Consult (Dr. Wells):** Reviewed case. Given rapid progression after only one cycle of Docetaxel following prolonged 1L chemo-IO, further systemic therapy options are limited and unlikely to provide significant benefit. Discussed prognosis (poor, likely months) and goals. Patient desires focus on quality of life, symptom control, avoiding further aggressive chemotherapy. Plan for best supportive care / symptom management.
  - **Supportive Care:** Pain managed with scheduled Acetaminophen + PRN Hydrocodone/APAP. Anxiety managed with Lorazepam PRN. Nutrition consult obtained for cachexia counseling.
  - **IPC Education:** Extensive education provided to patient and husband by IR nursing and home health liaison regarding IPC care, drainage procedure (plan for qod drainage initially), potential complications, and supplies. Home Health nursing arranged for initial IPC care support at home.
- **Discharge Readiness:** Patient clinically stable, dyspnea resolved on RA or minimal O2 (plan discharge on RA). IPC draining appropriately, drainage procedure understood by patient/family. Pain controlled on PO meds. Tolerating diet. Cleared for discharge home with Home Health and Hospice Information/Referral discussed (patient wishes to consider hospice but not enroll immediately).

DISCHARGE CONDITION: Stable. Afebrile. Respirations unlabored on RA. Pain controlled. IPC in place, functioning. Understanding of IPC care and f/u plan confirmed.

DISCHARGE MEDICATIONS:

- Acetaminophen 650 mg PO Q6H Scheduled
- Hydrocodone/Acetaminophen 5/325 mg 1-2 tabs PO Q6H PRN pain
- Lorazepam 0.5 mg PO Q8H PRN anxiety
- Senna-S 1 tab PO BID (prophylaxis)
- Pantoprazole 40 mg PO Daily (prior GERD)
- (Docetaxel Chemotherapy - Discontinued)

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DISCHARGE INSTRUCTIONS:

1. **Indwelling Pleural Catheter (IPC):** Drain catheter every other day (Mon/Wed/Fri initially) or as instructed by home health/oncology. Record drainage amount. Follow cleaning/dressing change instructions meticulously. Report fever, chills, catheter site redness/pain/drainage, sudden increase in pain or shortness of breath immediately.
2. **Activity:** As tolerated. Avoid strenuous activity involving right chest wall initially.
3. **Diet:** Regular diet, encourage high calorie/protein supplements.
4. **Medications:** Continue as prescribed. Call if pain not controlled or side effects occur.
5. **Follow-up Appointments:**
    - **Medical Oncology:** Dr. V. Wells in 1-2 weeks (Scheduled: 01/30/2023) to discuss supportive care plan, consider hospice further.
    - **Home Health Nurse:** Visit scheduled for tomorrow (01/21/2023) for IPC care check.
    - **Primary Care Physician:** Follow up as needed.
6. **Urgent Concerns:** Return to ED or call 911/Oncology Triage for sudden severe shortness of breath, chest pain, fever >100.4F, IPC complications, uncontrolled pain, neurological changes.

_____ M.D.
C. Ramirez, MD (Hospital Medicine - Electronically Signed)

PATIENT NAME: Johnson, Mary Elizabeth
PATIENT ID: SYN162
DATE OF BIRTH: July 29, 1962