Discharge Summary

Diagnostic Work-up

Initial PET/CT scan on 17 June 2022 demonstrated intense FDG uptake in right upper lobe mass, multiple lytic lesions (T8, L4, right iliac crest), and right-sided pleural nodularity. Biopsy of pleural nodule confirmed adenocarcinoma, TTF-1+, Napsin A+, consistent with lung origin.

Molecular profiling via Tempus xT panel confirmed presence of KIF5B-RET fusion with no other actionable co-mutations. ALK, ROS1, EGFR, KRAS – all negative. PD-L1 TPS was 15% (Dako 22C3), not sufficient for monotherapy checkpoint inhibition. TMB was 3.2 mut/Mb, microsatellite stable.

Treatment Course

First-line treatment with pralsetinib (BLU-667) was initiated on 08 July 2022 at 400 mg orally once daily. The patient tolerated treatment well with early symptom improvement, notably reduced pleuritic pain and improved appetite.

CT scans at 8 weeks and 16 weeks confirmed partial response, with >40% reduction in target lesions and stabilization of bone metastases. Zoledronic acid was introduced monthly for skeletal-related event (SRE) prevention. Calcium and vitamin D supplementation was advised.

Common adverse events included mild constipation, transient liver enzyme elevation (Grade 1), and anemia (Grade 2). No dose modifications required to date.

Follow-up imaging in January 2024 showed ongoing partial response with no new sites of disease. Brain MRI (January 2025) remained negative. Pralsetinib continued with sustained disease control. As of April 2025, the patient remains on active therapy with ECOG PS 1.

Comorbidities and Supportive Care

History of ischemic heart disease (post-stent placement in 2019) on dual antiplatelet therapy (aspirin 81 mg, clopidogrel 75 mg daily) and atorvastatin 40 mg. Hypertension managed with losartan 50 mg daily.

Bone health continues under monitoring; recent DEXA shows osteopenia. Pulmonary rehab was initiated to maintain functional status. Patient remains independent in ADLs.

Genetic counseling was provided given RET fusion, though currently no evidence suggests familial transmission.

Future Planning:

- Continued pralsetinib with close monitoring for resistance. Circulating tumor DNA (ctDNA) every 6 months.
- Plan for re-biopsy or plasma NGS upon progression to guide 2L options (e.g., selpercatinib or clinical trial).
- Multidisciplinary support ongoing with oncology, cardiology, and pain management.

Physician: Dr. A. Reyes, MD, Thoracic Oncology
Date of Discharge Note: 14 April 2025

Patient Name: Fabian Thomas (ID SYN197) born 12 July 1958