Palliative Care Inpatient Consult

INSTITUTION: Metropolitan General Hospital
SERVICE: Palliative Care Consultation
DATE OF CONSULTATION: 01/15/2023
PATIENT: Henderson, Thomas George **DOB:** 15-JAN-1952 **MRN:** SYN141

CONSULTING PHYSICIAN: Marcus Jones, MD (Palliative Care Fellow)
ATTENDING PHYSICIAN: Susan Lee, MD (Palliative Care Attending)
REFERRING PHYSICIAN: Kenji Tanaka, MD (Medical Oncology) via Hospital Medicine (Dr. Sharma)

REASON FOR CONSULTATION: Goals of care clarification and complex symptom management (severe pain, cachexia, existential distress) in a 71-year-old male with metastatic lung cancer refractory to multiple lines of therapy.

HISTORY OF PRESENT ILLNESS:
Mr. Henderson carries a diagnosis of Stage IV Lung Adenocarcinoma, diagnosed initially on November 24, 2021. His presentation at that time involved fatigue and debilitating right flank pain, ultimately attributed to large adrenal metastases (bilateral) and extensive osseous metastases (T/L spine, pelvis) found on staging workup, alongside a 2.5 cm LUL primary lung lesion. Brain MRI was negative. Molecular testing revealed **Wild-Type** status for common drivers, and PD-L1 IHC (22C3) was low at **TPS 8%, CPS 12, IC Score 1/+**.

He received first-line therapy with **Carboplatin/Pemetrexed/Pembrolizumab** starting December 16, 2021. He tolerated this fairly well and achieved stable disease for approximately **11 months**. Progression was noted in November 2022, primarily involving growth of adrenal lesions and worsening bone metastases (new lytic changes, increased FDG avidity).

He subsequently started second-line **Docetaxel** monotherapy in December 2022. This regimen was poorly tolerated, marked by significant Grade 3 fatigue, Grade 2 mucositis, and Grade 2 painful peripheral neuropathy after only two cycles. Restaging scans after Cycle 2 (February 2023) showed **further disease progression** in bone and adrenals, with development of new borderline hepatic lesions. His performance status declined significantly (ECOG 3).

Given the lack of response, poor tolerance to Docetaxel, and declining functional status, further systemic anti-cancer therapy was deemed inappropriate. He transitioned to best supportive care under Dr. Tanaka's supervision approximately one month ago.

Current Admission (Initiated 01/12/2023): Patient was admitted from home via ED due to a pain crisis. He reported escalating lower back and bilateral hip pain (10/10 severity) over the preceding week, refractory to his home regimen of Oxycontin 40mg BID + frequent Oxycodone 15mg PRN (taking q2-3h). He was also experiencing profound weakness, anorexia with ~15lb weight loss over the past month, severe constipation despite laxatives, and expressed feelings of hopelessness and being a "burden" to his wife. Hospital Medicine service admitted him for IV pain management, hydration, bowel cleanout, and consultation with Oncology/Palliative Care.

PAST MEDICAL HISTORY:

- Coronary Artery Disease s/p MI 2010 (medically managed - ASA, Metoprolol, Lisinopril, Atorvastatin)
- Type 2 Diabetes Mellitus (on Metformin, recent A1c 7.8%)
- Osteoarthritis (knees, hands)
- Benign Prostatic Hyperplasia
- Former Smoker (60 pack-years, quit 2015)

SOCIAL HISTORY: Retired electrician. Lives with his wife, Mary (age 69), who is his primary caregiver and appears loving but significantly stressed. Two adult children live locally and are involved. Patient was previously active in community theater prior to illness. Expresses frustration at loss of independence and function.

MEDICATIONS (Current Inpatient Regimen):

- Hydromorphone PCA (Basal 0.5mg/hr, Demand 0.5mg q15min, Lockout 30min) – *Total use ~25mg/24h*
- MS Contin 40mg PO BID (*Held since PCA initiation*)
- Acetaminophen 650mg PO Q6H Scheduled
- Gabapentin 300mg PO TID (Started yesterday for presumed neuropathic component)
- Polyethylene Glycol 3350 1 capful PO BID
- Senna-S 2 tabs PO BID
- Bisacodyl 10mg PR suppository daily PRN (Used x2, moderate result)
- Ondansetron 4mg IV Q6H PRN nausea (infrequent use)
- ASA 81mg daily, Metoprolol Succinate ER 50mg daily, Lisinopril 10mg daily, Atorvastatin 40mg daily, Metformin 1000mg BID, Tamsulosin 0.4mg daily.
- Lorazepam 0.5mg PO Q6H PRN anxiety (used frequently by patient request)

REVIEW OF SYSTEMS (Patient & Wife):

- **Pain:** Currently rated 5-6/10 (lumbar spine, hips), improved from 10/10 on admission but still significant, limits repositioning. Character described as deep, aching, constant.
- **Constitutional:** Profound fatigue/weakness ("can barely lift my head"). Anorexia ("no appetite at all"). Cachexia evident.
- **GI:** Nausea infrequent. Severe constipation ongoing despite aggressive regimen. Abdomen soft but slightly distended.
- **Resp:** No dyspnea at rest. Mild cough.
- **Neuro:** Alert, oriented x3. Appears weary. No focal deficits. Reports painful neuropathy feet > hands (Grade 2, chronic from Docetaxel).
- **Psych:** Expresses sadness, hopelessness, "ready for this to be over." Denies active suicidal ideation but states "wouldn't mind not waking up." Tearful during discussion. Expresses concern for wife. Anxiety prominent, requesting frequent Lorazepam.

OBJECTIVE:

- *Vitals:* T 37.0, BP 118/70, HR 85, RR 18, SpO2 96% RA.
- *Exam:* Chronically ill, cachectic male lying in bed, appears stated age. Alert, oriented, follows commands but speaks slowly, flat affect. Mucous membranes dry. Lungs clear. Cor RRR. Abd soft, slightly distended, hypoactive BS. Ext: Marked muscle wasting, no edema. Neuropathy exam:

Decreased sensation to light touch below ankles, 1+ reflexes LE. Requires max assist for repositioning due to pain/weakness. ECOG Performance Status 4.

- *Labs:* Hgb 9.8 (baseline ~11), WBC 6.5, Plt 160. Cr 1.3 (baseline ~1.0), BUN 40. Albumin 2.1. Calcium 9.2. Alk Phos 650 (up from ~400 pre-docetaxel). LFTs normal. Glucose 150-220 range.

ASSESSMENT:

Mr. Henderson is a 71-year-old man with end-stage metastatic lung cancer refractory to standard therapies, now admitted with a pain crisis and severe functional decline (ECOG 4). His primary issues include:

1. **Severe Malignant Bone Pain:** Partially responsive to current IV opioid regimen, likely multifactorial (nociceptive +/- neuropathic). May benefit from opioid rotation, increased adjuvants, and potentially palliative RT if feasible/consistent with goals.
2. **Cancer Cachexia-Anorexia Syndrome:** Severe, contributing to profound weakness and fatigue.
3. **Opioid-Induced Constipation:** Severe, refractory to standard measures, potentially contributing to abdominal discomfort/anorexia. Requires aggressive management, possible disimpaction.
4. **Existential Distress / Depressed Mood / Anxiety:** Significant emotional suffering related to terminal prognosis, loss of function, and symptom burden. Requires psychosocial and spiritual support, potentially pharmacological intervention for mood/anxiety.
5. **Prognosis:** Very poor, likely weeks. Meets criteria for hospice level of care.

RECOMMENDATIONS & PLAN:

1. **Goals of Care Clarification:** Revisit GOC with patient and wife explicitly. Based on today's discussion, patient prioritizes comfort, wishes to avoid aggressive measures, and understands prognosis is limited. Affirms **DNR/DNI** status. Expressed desire for eventual discharge home *if possible*, but acknowledges inpatient hospice may be necessary if symptoms cannot be managed adequately for home setting.
2. **Pain Management:**
    - **Opioid Rotation:** Consider rotating from Hydromorphone PCA to **Methadone** due to potential for improved neuropathic pain coverage, longer half-life, and possibly less constipation (though requires careful initiation/titration). Propose starting Methadone 2.5mg PO TID scheduled, while rapidly weaning PCA basal rate over 24-48h (continue demand doses PRN initially). Monitor closely for sedation/respiratory depression. *Alternative: Continue Hydromorphone, convert PCA to scheduled SC/PO long-acting + breakthrough.*
    - **Adjuvants:** Continue Gabapentin 300mg TID, may slowly titrate up to 600mg TID if tolerated and renal function stable, monitoring sedation. Continue scheduled Acetaminophen. Continue Dexamethasone 4mg BID for potential anti-inflammatory/analgesic effect, monitor side effects (glucose, mood).
    - **Palliative RT:** Discuss feasibility/benefit with Radiation Oncology, *even in setting of poor PS*, targeting lumbar spine/pelvis if consistent with comfort goals (e.g., single 8 Gy fraction). May offer best chance for significant pain reduction allowing potential discharge. Initiate consult today.
3. **Constipation: STAT Abdominal X-ray (KUB)** to assess stool burden/rule out obstruction. **Manual disimpaction** if indicated. Start scheduled **Methylnaltrexone (Relistor)** 12mg SC daily or every other day while on significant opioids if no obstruction. Continue Miralax BID + Bisacodyl suppository daily PRN. Aggressive hydration as tolerated.

4. **Nausea/Anorexia:** Continue Ondansetron PRN. Haloperidol 0.5mg PO BID scheduled may help nausea and has benefit for delirium/agitation if needed. Encourage small amounts preferred foods for pleasure only. Dexamethasone may help appetite short term.
5. **Fatigue/Weakness:** Acknowledge largely irreversible. Energy conservation. PT/OT consult for evaluation of durable medical equipment (DME) needs (e.g., hospital bed, commode, lift) for potential home discharge planning.
6. **Psychosocial/Spiritual:** Continue Lorazepam 0.5mg PO Q6H scheduled for anxiety baseline (rather than PRN). Consider trial of Mirtazapine 7.5-15mg QHS for potential benefit on mood, sleep, and appetite. Chaplain consult requested. Social Work actively involved re: disposition planning, caregiver support.
7. **Disposition:** Collaborate with SW/CM. Assess response to pain interventions (esp RT, Methadone trial) and bowel management over next few days. Determine feasibility of Home Hospice vs. transfer to Inpatient Hospice Facility based on symptom control and caregiver capacity/support.

Thank you for involving Palliative Care. We will follow closely with the primary team.

_____ M.D.
Marcus Jones, MD (Palliative Fellow) / Susan Lee, MD (Palliative Attending - Electronically Signed)

Follow up: Patient died on 01/19/2023