Oncology Consult Note (Poor Prognosis / GOC Focus)

Metropolitan General Hospital – Oncology Consultation Service

MRN: SYN125 **PATIENT:** Michealson, John Joseph

REASON FOR CONSULTATION: Evaluate patient with newly diagnosed Stage IV NSCLC presenting with severe debilitating bone pain and poor performance status; discuss treatment options, prognosis, and establish goals of care. Patient admitted to hospital 3 days ago for pain crisis.

HISTORY OF PRESENT ILLNESS:
Mr. Michealson (born 05/27/1949) is a 70-year-old gentleman with a significant smoking history who presented to his PCP 1 month ago with insidious onset but rapidly progressive, severe low back and bilateral hip pain, making ambulation extremely difficult. He also reported significant fatigue, anorexia, and ~20 lb unintentional weight loss over 2-3 months. Initial workup by PCP included spinal X-rays (degenerative changes, ? lytic lesions) and basic labs (mild anemia, elevated Alk Phos). He was referred to Orthopedics, who ordered an urgent MRI of the lumbar spine.

DIAGNOSTIC WORKUP (Performed prior to and during current admission):

- **MRI Lumbar Spine (Oct 1, 2019):** Revealed diffuse abnormal marrow signal throughout the visualized lumbar vertebrae and sacrum/pelvis, highly suspicious for extensive osseous metastatic disease. Showed multilevel degenerative disc disease but no acute cord compression.
- **CT Chest/Abdomen/Pelvis w/ Contrast (Staging, Oct 3, 2019):**
    - *Chest:* Revealed a 5.5 cm spiculated mass in the right lower lobe with associated hilar and mediastinal lymphadenopathy (subcarinal node 2.8 cm).
    - *Abdomen/Pelvis:* No definite hepatic or adrenal metastases. Confirmed extensive sclerotic and lytic osseous metastases throughout the visualized skeleton (thoracic/lumbar spine, ribs, sternum, pelvis, proximal femora).
- **Bone Scan (Oct 5, 2019):** Confirmed extensive "super scan" appearance consistent with widespread osseous metastatic disease.
- **Brain MRI w/wo Contrast (Oct 6, 2019):** Negative for intracranial metastases.
- **CT-Guided Biopsy of L4 Vertebral Lesion (Oct 8, 2019):**
    - **Pathology Report (Oct 12, 2019): Poorly Differentiated Carcinoma**, favoring Non-Small Cell Lung Cancer based on morphology and limited IHC panel (Positive for Pan-Cytokeratin; Negative for TTF-1, Napsin-A, P40, GATA-3, PSA). Considered likely lung primary given imaging findings.
    - **Molecular Testing (NGS Panel - attempted on bone biopsy): Failed / Quantity Not Sufficient (QNS)** for comprehensive analysis due to decalcification process/low tumor cellularity.
    - **PD-L1 IHC (22C3 - performed on limited material):** Estimated **TPS 0%, CPS <5, IC Score 0**.

SUMMARY OF DIAGNOSIS: Oct 3, 2019 diagnosed Stage IV (cT3N2M1b - Bone) Poorly Differentiated Carcinoma, Strongly Favored NSCLC based on clinical/radiographic picture, PD-L1 Negative. Molecular profile unknown due to QNS sample.

Clinical Course Leading to Admission: After diagnosis, patient was started on opioid analgesics (initially Tramadol, then hydrocodone/APAP) with partial relief. He received his first cycle of Carbo/Pacli/Pem in November 2019. However, a few days starting chemo, his pain escalated dramatically, becoming intractable at home despite increasing opioid doses. He developed severe weakness, inability to ambulate independently, decreased PO intake, and presented to the ED 3 days ago in a pain crisis, leading to this admission.

Current Status (Inpatient): Radiology today showed rapid disease progression. Patient remains hospitalized on the Medicine service. Pain is now better controlled after transitioning to IV Hydromorphone PCA and initiation of scheduled long-acting Morphine Sulfate ER (MS Contin). He remains extremely fatigued, requires significant assistance with ADLs, and spends >75% of day in bed. Appetite is poor. Performance Status is clearly ECOG 3-4.

PAST MEDICAL HISTORY: Severe COPD (on multiple inhalers, prior hospitalizations), Coronary Artery Disease s/p CABG x 4 (2005), Peripheral Vascular Disease s/p L fem-pop bypass, Hypertension, Chronic Kidney Disease Stage IIIa (baseline Cr ~1.4), Heavy Smoker (80+ pack-years, continued until recent illness).

SOCIAL HISTORY: Retired construction worker. Lives alone in apartment (supportive daughter lives nearby). Limited social support otherwise.

REVIEW OF SYSTEMS: Dominated by severe diffuse bone pain (now controlled to 4-5/10), profound fatigue/weakness, anorexia, constipation (on bowel regimen). Denies SOB at rest, cough, fever. Alert but appears weary, affect flat.

OBJECTIVE:

- *Vitals:* Stable on admission, now T 37.0, BP 125/70, HR 80, RR 18, SpO2 95% RA.
- *Exam:* Chronically ill, cachectic male resting in bed. Appears older than stated age. Requires assistance to sit up. Lungs: Distant breath sounds, no crackles/wheezes. Cor: RRR. Abd: Soft. Ext: Muscle wasting, no edema. Diffuse bony tenderness elicited with minimal palpation/log-rolling. ECOG PS 3-4.
- *Labs (Admission):* Hgb 10.1, WBC 8.8, Plt 190. Cr 1.6, BUN 38. Albumin 2.5. Calcium 10.5 (mild hypercalcemia). Alk Phos 780 U/L. LFTs normal.

ASSESSMENT:
Mr. Michealson is a 70-year-old gentleman with extensive Stage IV poorly differentiated NSCLC metastatic primarily to bone, presenting with a pain crisis and severely debilitated performance status (ECOG 3-4). His PD-L1 expression is negative, and molecular profiling failed. He has significant medical comorbidities (severe COPD, CAD, PVD, CKD) and limited social support. His prognosis is exceptionally poor, likely weeks to very few months, regardless of treatment. The potential benefits of cytotoxic chemotherapy are highly unlikely to outweigh the risks and burdens in his current condition.

PLAN & RECOMMENDATIONS:

1. **Goals of Care Discussion:** Held lengthy, frank discussion with Mr. Michealson and his daughter regarding the diagnosis, extensive disease burden, poor performance status, significant comorbidities, inability to obtain molecular data, and extremely poor prognosis. Discussed the potential harms and very low likelihood of meaningful benefit from systemic chemotherapy in his current state (high risk of toxicity, unlikely to improve QOL or significantly extend life). Explored patient's values and priorities, which centered on **avoiding suffering, minimizing burdensome interventions, and focusing on comfort.** Patient verbalized understanding that his condition is terminal and expressed desire to **forgo cytotoxic chemotherapy**. He wishes to focus on pain control and quality of life. Agreed to **Do Not Resuscitate / Do Not Intubate (DNR/DNI)** status.
2. **Systemic Therapy: No systemic anti-cancer therapy recommended.**
3. **Palliative Radiation Oncology Consultation:** STAT consult requested today for evaluation for **palliative radiotherapy** to the most symptomatic bone sites (likely lumbosacral spine and potentially hips) for pain management. This represents the best potential intervention to improve his primary symptom.
4. **Pain & Symptom Management:**
    - Continue current opioid regimen (MS Contin + PCA or PRN SC/IV/PO breakthrough), titrate aggressively as needed for comfort, guided by Palliative Care Service (consult requested).
    - Continue aggressive bowel regimen.
    - **Dexamethasone:** Recommend starting Dexamethasone 4 mg PO/IV BID for potential benefit on pain, appetite, fatigue, and sense of well-being (discuss short-term use, risks/benefits).
    - Manage hypercalcemia conservatively with hydration initially; consider bisphosphonate (e.g., single dose Zoledronic acid) primarily for bone pain palliation *after* RT consult and if renal function permits/stabilizes, but not urgently needed for calcium level alone given palliative goals.
5. **Discharge Planning:** Primary goal is safe discharge with appropriate level of care focused on comfort. Given ECOG 3-4 status, severe pain requiring ongoing titration, and limited home support:
    - **Inpatient Hospice Facility:** Strongly recommended as most appropriate setting for managing complex symptoms and providing end-of-life care.
    - **Home Hospice:** Likely not feasible unless significant improvement post-RT AND robust 24/7 caregiver support can be arranged (seems unlikely).
    - **Palliative Care & Social Work/Case Management Consults:** Essential for ongoing symptom management recommendations, assisting with GOC reinforcement, and facilitating disposition to hospice.
6. **Follow-up:** Will co-manage with Hospital Medicine, Palliative Care, and Radiation Oncology while inpatient. Primary focus is symptom control and safe disposition to hospice.

Thank you for this consultation to assist in clarifying goals and management for this complex patient.

_____ M.D.
Vivian Wells, MD (Medical Oncology - Electronically Signed)

DATE OF CONSULTATION: December 10, 2019
CONSULTING PHYSICIAN: Vivian Wells, MD (Medical Oncology)
REFERRING PHYSICIAN: Gregory House, MD (Internal Medicine)

NOTE: Patient deceased on December 12, 2019