VETERANS AFFAIRS HEALTHCARE SYSTEM

ONCOLOGY SERVICE

DISCHARGE SUMMARY

- **DATE OF ADMISSION:** April 1, 2024
- **DATE OF DISCHARGE:** April 14, 2024
- **ATTENDING PHYSICIAN:** Robert Thompson, MD (Oncology)
- **CONSULTING SERVICES:** Palliative Care, Radiation Oncology, Neurosurgery, Pulmonology

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IDENTIFICATION DATA:

- **PATIENT:** Jonas Mess (MRN SYN209)
- **DOB:** May 9, 1949

DISCHARGE DIAGNOSES:

1. Terminal progression of metastatic non-small cell lung cancer with leptomeningeal disease
2. Malignant pleural effusion
3. Severe cancer-related pain
4. Cancer cachexia
5. Steroid-induced hyperglycemia

COMPREHENSIVE ONCOLOGIC HISTORY:

This Vietnam veteran with 60 pack-year smoking history (quit 2012) was initially diagnosed with NSCLC in October 2019 after presenting with persistent headache and left-sided weakness. Initial imaging revealed a 5.6 cm right upper lobe mass with multiple brain metastases (3 lesions, largest measuring 2.8 cm in right parietal lobe). Biopsy of the lung mass confirmed poorly differentiated

adenocarcinoma. Molecular testing was negative for actionable mutations and showed low PD-L1 expression (<1%).

Initial Management (2019-2020):

- Whole brain radiation therapy (WBRT) 30 Gy in 10 fractions (completed 11/2019)
- First-line systemic therapy with carboplatin/pemetrexed/pembrolizumab initiated 10/25/2019
- Initial partial response with 40% reduction in primary tumor size
- Progressive disease documented 06/21/2020

Subsequent Course (2020-2021):

- Second-line docetaxel initiated 07/2020
- Disease stabilization for 4 months, then progression
- Third-line gemcitabine started 12/2020
- Minimal clinical benefit with progression after 2 cycles
- Development of symptomatic pleural effusion requiring pleurodesis (02/2021)
- Clinical trial participation: Phase I study of novel CDK7 inhibitor (03/2021-05/2021)
- Withdrawn from trial due to toxicity (grade 3 hepatitis)

Later Course (2021-2024):

- Fourth-line vinorelbine (06/2021-08/2021) with no clinical benefit
- Best supportive care approach adopted 09/2021
- Multiple hospitalizations for symptom management:
    - Malignant bowel obstruction requiring G-tube placement (11/2021)
    - Pathologic femoral fracture with surgical fixation (04/2022)
    - SVC syndrome requiring stent placement (08/2022)
    - Recurrent pleural effusions with tunneled pleural catheter placement (01/2023)
- Palliative radiation to painful bone metastases (various sites, 2021-2023)
- Maintained on dexamethasone for CNS disease with frequent dose adjustments

Recent Status (Early 2024):

- Gradual functional decline with ECOG PS deterioration from 2 to 3
- Development of new neurological symptoms (diplopia, hearing loss, gait instability)
- MRI brain/spine (03/2024) revealed extensive leptomeningeal disease

- CSF cytology positive for malignant cells
- Patient expressed desire to avoid hospitalization and pursue comfort-focused care at home
- Enrolled in home hospice program but experienced inadequate symptom control

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CURRENT HOSPITAL COURSE:

Despite home hospice enrollment, patient was admitted for uncontrolled symptoms, primarily intractable headache, progressive confusion, and severe back pain. Initial evaluation showed signs of increased intracranial pressure, dehydration, and poor pain control. Patient was classified as "actively dying" by the emergency department team.

After discussion with family and review of advance directives, the decision was made to pursue short-term aggressive symptom management while maintaining comfort-focused goals. Patient received high-dose dexamethasone (10 mg IV q6h initially) with rapid improvement in neurological symptoms. Pain management was optimized with hydromorphone PCA, later transitioned to continuous subcutaneous infusion.

Imaging studies confirmed extensive disease progression with new spinal cord compression at T6-T7. Given comfort-focused goals, neither neurosurgical intervention nor additional radiation therapy was pursued. Instead, dexamethasone dose was adjusted to optimize symptom control while minimizing side effects.

Nutrition and hydration were provided as tolerated for comfort only. Speech therapy assisted with swallowing evaluation and recommendations for safe oral intake. Physical and occupational therapy provided recommendations for positioning and comfort measures. Recurrent pleural effusion was managed conservatively.

After initial symptomatic improvement, interdisciplinary team discussions focused on appropriate disposition. Patient and family expressed strong preference for inpatient hospice setting rather than return to home hospice, citing complexity of care needs. Arrangements were made for transfer to inpatient hospice unit with continuation of current comfort measures.

HOSPITAL INTERVENTIONS:

1. **Medications:**
    - Dexamethasone: Initiated at 10 mg IV q6h, tapered to 6 mg IV q6h by discharge
    - Pain management: Hydromorphone continuous subcutaneous infusion at 0.5 mg/hr with 0.5 mg q20min PRN
    - Glycopyrrolate: Added for secretion management
    - Haloperidol: Low-dose for terminal agitation
2. **Laboratory Monitoring (Limited per goals of care):**
    - Comprehensive metabolic panel (04/02/2024): Na 132, K 4.2, Cl 96, CO2 25, BUN 32, Cr 1.4, Glucose 212
    - CBC (04/02/2024): WBC 12.4, Hgb 9.6, Platelets 142
    - Subsequent labs limited to point-of-care glucose monitoring for steroid management
3. **Diagnostic Imaging:**
    - MRI brain (04/02/2024): Extensive leptomeningeal enhancement with progression of parenchymal disease, moderate hydrocephalus
    - MRI spine (04/02/2024): Diffuse leptomeningeal enhancement, epidural extension at T6-T7 with cord compression, multiple vertebral body metastases
4. **Procedures:**
    - Central venous access (PICC) for medication administration
    - No invasive procedures beyond comfort-focused interventions
5. **Consultations:**
    - Palliative Care: Daily management with focus on symptom control
    - Neurology: Evaluation of neurological deterioration
    - Radiation Oncology: Assessment for palliative radiation (declined given goals)
    - Ethics: Support for goals of care conversations

HOSPITAL COURSE BY SYSTEM:

Neurological:

- Initial Glasgow Coma Scale 13 improving to 15 with steroid therapy
- Persistent diplopia and hearing loss unchanged
- Headache improved from 9/10 to 2-3/10 with medication management
- Episodic confusion requiring low-dose haloperidol as needed

Respiratory:

- Oxygen therapy via nasal cannula at 2L for comfort
- Right-sided pleural effusion managed conservatively

- Respiratory rate 16-22, no significant distress

Cardiovascular:

- Stable vital signs throughout admission
- No significant arrhythmias noted
- Generalized edema improved with elevation and medication adjustments

Gastrointestinal:

- Poor oral intake with preference for soft foods and liquids
- Bowel regimen adjusted to prevent opioid-induced constipation
- No nausea with current medication regimen

Renal/Metabolic:

- Mild prerenal azotemia improved with gentle hydration
- Steroid-induced hyperglycemia managed with sliding scale insulin
- Electrolyte imbalances corrected

Functional Status:

- Dependent for all activities of daily living
- Bed-bound with ability to reposition with maximal assistance
- ECOG Performance Status 4

DISCHARGE PLAN:

Disposition: Transfer to inpatient hospice unit

Medications at Transfer:

1. Dexamethasone 6 mg IV q6h
2. Hydromorphone continuous subcutaneous infusion at 0.5 mg/hr
3. Hydromorphone 0.5 mg subcutaneous q20min PRN breakthrough pain
4. Haloperidol 0.5 mg subcutaneous q4h PRN agitation/delirium
5. Glycopyrrolate 0.2 mg subcutaneous q4h PRN secretions
6. Lorazepam 0.5 mg sublingual q4h PRN anxiety/dyspnea
7. Acetaminophen 1000 mg per feeding tube q6h PRN
8. Senna-docusate 2 tablets per feeding tube daily
9. Insulin regular sliding scale PRN (for glucose >200 mg/dL)

Comfort Care Plans:

1. No CPR, no intubation, no transfer to ICU (per advance directive)
2. No laboratory testing unless directly impacts symptom management
3. No vital sign monitoring unless clinically indicated for symptom assessment
4. Oral care, skin care, and repositioning protocols implemented
5. Family visitation without restriction

Equipment/Supplies:

1. Hospital bed with pressure-relieving mattress
2. Oxygen concentrator with nasal cannula
3. Suction equipment
4. CADD pump for medication infusion

Prognosis: Poor, with expected survival measured in days to weeks

Family Education: Comprehensive education provided regarding terminal phase of illness, expected changes in condition, medication purposes, and communication with hospice team. Family demonstrated understanding and acceptance of current status.

CONDITION AT DISCHARGE: Patient is awake but somnolent, opening eyes to voice, following simple commands intermittently. Comfortable with current pain regimen. Minimal oral intake. Hemodynamically stable. Ready for transfer to inpatient hospice setting for continued end-of-life care.

FOLLOW-UP: Patient succumbed on April 20, 2024.

Dictated by: Robert Thompson, MD
Attending Physician, Oncology Service

Co-signed by: Sarah Miller, MD
Palliative Care Service

Date: April 14, 2024