Metropolitan General Hospital - Discharge Summary

PATIENT: PENDELTON, Arthur Morgan
MRN: SYN149
DATE OF BIRTH: 1946-12-01
ATTENDING PHYSICIAN: Dr. Ramirez, Carlos (Hospital Medicine)
CONSULTING PHYSICIAN: Dr. Vivian Wells (Medical Oncology)

DATE OF ADMISSION: 2022-01-28
DATE OF DISCHARGE: 2022-02-09

ADMISSION DIAGNOSES:

1. Acute Kidney Injury (AKI), Stage II (KDIGO Criteria)
2. Hyperkalemia (Moderate)
3. Dehydration
4. Progressive Metastatic Non-Small Cell Lung Cancer (Adenocarcinoma)
5. Fatigue & Malaise

DISCHARGE DIAGNOSES:

1. **Resolved** Acute Kidney Injury (Stage II), likely pre-renal secondary to dehydration and potentially exacerbated by recent disease progression/systemic inflammation. Baseline CKD Stage IIIa (eGFR ~50s).
2. **Resolved** Hyperkalemia.
3. **Resolved** Dehydration.
4. **Primary Underlying Condition:** Stage IV Lung Adenocarcinoma, Wild-Type (EGFR/ALK/ROS1/BRAF/KRAS/MET/RET negative), PD-L1 High (TPS 80%), status post progression on first-line Pembrolizumab. Recently initiated second-line chemotherapy (Docetaxel).
5. **Comorbidities:**
    - Chronic Kidney Disease Stage IIIa (Baseline Cr ~1.4-1.5 mg/dL, eGFR 50-55 ml/min/1.73m²)
    - Paroxysmal Atrial Fibrillation (on Apixaban)
    - Hypertension (on Lisinopril, Amlodipine)
    - Hyperlipidemia (on Atorvastatin)
    - Gout (on Allopurinol)
    - History of Tobacco Use (45 pack-years, quit 1999)

REASON FOR ADMISSION:
Mr. Pendelton was brought to the Emergency Department by his daughter due to progressive weakness, lethargy, decreased oral intake, and decreased urine output over the preceding 3-4 days. He received his first cycle of second-line Docetaxel chemotherapy 10 days prior (2022-01-18) for progressive lung cancer.

PERTINENT ONCOLOGIC HISTORY:

- Diagnosed February 20, 2020, with Stage IV Lung Adenocarcinoma after presenting with abdominal discomfort.
- **Initial Staging (Feb 2020):** CT C/A/P revealed a 4 cm LUL primary mass, mediastinal adenopathy, multiple bilobar liver metastases (largest 3.5 cm segment

VII), and bilateral adrenal metastases (Left 2.5 cm, Right 1.8 cm). Brain MRI negative.
- **Pathology (Liver Biopsy 02/24/2020):** Metastatic Adenocarcinoma, consistent with lung primary (TTF-1+, Napsin-A+).
- **Molecular Testing (NGS):** Wild-Type for common drivers.
- **PD-L1 (IHC 22C3):** TPS 80%, CPS 85, IC Score 3/+.
- **First-Line Therapy:** Pembrolizumab 200 mg IV q3 weeks, initiated March 15, 2020. Experienced good partial response and disease stability initially. Tolerated well with only mild fatigue and Grade 1 rash initially.
- **Progression (Jan 2022):** Surveillance CT scans on 2022-01-10 showed unequivocal progression with significant increase in size and number of liver metastases (largest now 5.2 cm), growth of adrenal lesions, and slight increase in primary tumor size. Pembrolizumab discontinued.
- **Second-Line Therapy:** Initiated Docetaxel 75 mg/m2 IV q3 weeks on 2022-01-18.

HOSPITAL COURSE:
On arrival, Mr. Pendelton was lethargic but oriented. Vitals: T 37.2C, BP 105/65, HR 90 (irregularly irregular - Afib), RR 18, SpO2 96% RA. Exam notable for dry mucous membranes, decreased skin turgor, clear lungs, soft abdomen.

- **Initial Labs:** WBC 6.8, Hgb 11.5, Plt 180. Na 135, K 6.2 mmol/L, Cl 100 , CO2 20, BUN 55 mg/dL, Cr 3.8 mg/dL (baseline ~1.4-1.5), Glucose 110. Calcium 8.8. LFTs stable (AST 45, ALT 50, Alk Phos 210, T Bili 0.9). Urinalysis showed concentrated urine, no casts. ECG confirmed Atrial Fibrillation, rate 80-100, no acute ischemic changes, peaked T waves noted.
- **Management:**
    - **AKI/Hyperkalemia:** Admitted to telemetry floor. Aggressive IV hydration initiated (0.9% NaCl at 150 ml/hr initially, then adjusted based on response/urine output). Received Kayexalate 30g PO x 1 dose, Insulin 10 units IV + D50W. Furosemide 40mg IV x 1 given after initial hydration improved volume status. Serial labs monitored closely. Potassium normalized within 12 hours (4.5 mmol/L). Creatinine peaked at 3.9 mg/dL on Day 2, then steadily improved with hydration, down to 1.8 mg/dL by discharge (eGFR ~40). Urine output improved significantly.
    - **Dehydration/Intake:** Encouraged oral fluids as tolerated, IV fluids continued until euvolemic. Nutrition consult obtained; patient resumed regular diet by Day 2.
    - **Medication Adjustments:** Lisinopril held during acute phase of AKI, restarted at half dose (5mg daily) prior to discharge. Apixaban continued at standard dose (5mg BID) after confirming CrCl remained >30 ml/min. Allopurinol continued. Atorvastatin continued.
    - **Oncology:** Dr. Wells (Oncology) consulted. Agreed AKI likely pre-renal, possibly exacerbated by systemic effects post-chemo initiation, but not definite chemo toxicity. No specific intervention required from oncology perspective during admission. Plan is to proceed cautiously with Cycle 2 of Docetaxel, likely with dose reduction (e.g., to 60 mg/m2) and emphasis on pre-hydration, pending follow-up assessment and renal function stability.
    - **Mobility:** Physical therapy evaluation showed generalized weakness/deconditioning. Patient ambulated with rolling walker by discharge.

DISCHARGE CONDITION:
Clinically stable. Alert and oriented x3. Euvolemic. Tolerating PO intake. Ambulating with walker. Atrial fibrillation rate controlled. Renal function significantly improved, approaching baseline. Potassium normal. Pain controlled with occasional Tylenol.

DISCHARGE MEDICATIONS:

1. Apixaban 5 mg PO BID
2. Lisinopril 5 mg PO Daily (*Restarted at reduced dose*)
3. Amlodipine 10 mg PO Daily
4. Atorvastatin 40 mg PO Daily
5. Allopurinol 300 mg PO Daily
6. Acetaminophen 650 mg PO Q6H PRN pain
7. **HOLD:** Docetaxel (Next cycle TBD based on outpatient Oncology f/u)
8. **DISCONTINUED during admission, not restarted:** Kayexalate, IV Fluids, Insulin/D50

DISCHARGE INSTRUCTIONS:

1. **Hydration:** Drink plenty of fluids (at least 6-8 glasses daily) unless instructed otherwise. Monitor urine output.
2. **Diet:** Resume regular diet. Monitor appetite.
3. **Activity:** Ambulate with walker as needed. Gradually increase activity as tolerated. Follow up with outpatient PT if arranged.
4. **Medications:** Take medications as prescribed. Note dose change for Lisinopril.
5. **Follow-up Appointments:**
    - **Medical Oncology:** Dr. Wells clinic in 7-10 days (Scheduled: 2022-02-10 @ 11:00 AM). Need CBC, CMP drawn 1-2 days prior to assess renal function and counts before decision on next chemo cycle.
    - **Primary Care Physician (PCP):** Follow up within 2 weeks for general check and BP monitoring.
6. **Urgent Concerns:** Return to ED or call 911 for dizziness, fainting, decreased urine output, shortness of breath, chest pain, signs of bleeding, fever >100.4F, or worsening weakness/lethargy. Call Oncology clinic with questions about chemotherapy or cancer symptoms.

PROGNOSIS: Fair to guarded given progression to second-line therapy and recent complication requiring hospitalization. Response to Docetaxel uncertain.

_____ M.D./D.O.
Carlos Ramirez, MD (Electronically Signed)
Hospital Medicine Service