METROPOLITAN MEDICAL CENTER

ONCOLOGY DEPARTMENT - DISCHARGE SUMMARY

CONFIDENTIAL PATIENT INFORMATION

Patient: Ronald Thompson (ID: SYN032)
Date of Birth: 11/11/1947

Admission Date: 03/28/2025
Discharge Date: 04/08/2025
Attending Physician: Dr. James Wilson

PRIMARY DIAGNOSIS:

Stage IV Non-Small Cell Lung Cancer (adenocarcinoma), wild-type for actionable mutations, with metastases to lung and liver

- Date of initial diagnosis: 08/22/2019
- PDL1 status: Positive, TPS ≥50% (actual score 85%)
- Driver mutations: None detected (wild-type)

COMORBIDITIES:

1. Coronary artery disease s/p CABG (2012)
2. Chronic obstructive pulmonary disease (COPD), moderate
3. Hyperlipidemia
4. Osteoarthritis
5. Benign prostatic hyperplasia (BPH)
6. History of tobacco use (60 pack-years, quit 2012)

SUMMARY OF DISEASE COURSE:

- Initial diagnosis: 08/22/2019
- First-line treatment: Pembrolizumab monotherapy (09/13/2019 - 03/15/2021)
- Second-line treatment: Docetaxel/Ramucirumab (04/2021 - 12/2021)
- Third-line treatment: Gemcitabine/Vinorelbine (01/2022 - 04/2022)
- Fourth-line treatment: Clinical trial NCT03834948 (05/2022 - 01/2023)
- Fifth-line treatment: Carboplatin/nab-Paclitaxel (02/2023 - 07/2023)
- Sixth-line treatment: Nivolumab (08/2023 - 05/2024)
- Seventh-line treatment: Vinorelbine monotherapy (06/2024 - 04/2025)

REASON FOR ADMISSION:

Patient admitted with increasing shortness of breath, fatigue, and new-onset right upper quadrant pain. Prior to admission, patient noted decreased appetite and unintentional weight loss of 12 pounds over the past 3 months.

HISTORY OF PRESENT ILLNESS:

Mr. Thompson is a 77-year-old male with a history of NSCLC diagnosed in August 2019. Initial presentation included cough, hemoptysis, and 30-pound weight loss. Imaging at that time revealed a 5.8 cm left upper lobe mass with ipsilateral lung metastases and three hepatic lesions. Biopsy confirmed adenocarcinoma, PDL1 strongly positive (TPS 85%). Molecular testing negative for EGFR, ALK, ROS1, BRAF, MET, RET, and NTRK alterations.

Patient was started on pembrolizumab monotherapy 200mg IV every 3 weeks on 09/13/2019. He experienced initial partial response with reduction in tumor burden and symptomatic improvement. Treatment was well-tolerated with only grade 1 fatigue and grade 1 pruritus as adverse events.

After 18 months of treatment (March 2021), disease progression was documented with increase in size of primary tumor and hepatic lesions. Patient was transitioned to second-line docetaxel/ramucirumab, which he received for 12 cycles with stable disease. In December 2021, progression was again noted, and he was started on third-line gemcitabine/vinorelbine. After 4 cycles, therapy was discontinued due to toxicity and minimal response.

In May 2022, patient was enrolled in clinical trial NCT03834948 evaluating novel KRAS G12C inhibitor plus anti-TIGIT antibody. He continued on trial for 8 months until January 2023, when disease progression led to trial discontinuation.

Subsequently, patient received fourth-line treatment with carboplatin/nab-paclitaxel from February 2023 to July 2023, followed by fifth-line nivolumab from August 2023 to May 2024. Most recently, patient has been receiving sixth-line vinorelbine monotherapy since June 2024, with poor tolerance and minimal response.

HOSPITAL COURSE:

Imaging Studies:

- CT Chest/Abdomen/Pelvis (03/29/2025): Left upper lobe primary mass measuring 7.8 cm (increased from 6.5 cm in January 2025). New right lower lobe 3.2 cm mass. Multiple bilateral pulmonary nodules. Enlarged mediastinal lymphadenopathy with largest node measuring 2.5 cm. Liver lesions increased in number (>12) and size with largest measuring 5.7 cm in right lobe. New lytic lesions in L3 and right iliac bone not previously reported.
- PET/CT (03/31/2025): Hypermetabolic activity in all known tumor sites. SUVmax of primary tumor 18.2. Liver lesions with SUVmax ranging from 12.4-16.8. New osseous metastatic disease in L3 (SUVmax 9.6) and right iliac bone (SUVmax 8.4).
- Brain MRI (04/01/2025): No evidence of intracranial metastatic disease.

Laboratory Values at Admission:

- WBC: 11.2 K/μL (elevated)
- Hemoglobin: 9.8 g/dL (decreased)

- Platelets: It's great to help you with these detailed discharge notes!118 K/µL (decreased)
- Sodium: 136 mEq/L
- Potassium: 3.9 mEq/L
- Chloride: 100 mEq/L
- CO2: 22 mEq/L
- BUN: 32 mg/dL (elevated)
- Creatinine: 1.4 mg/dL (elevated)
- Glucose: 142 mg/dL (elevated)
- Calcium: 9.2 mg/dL
- Total protein: 6.0 g/dL (decreased)
- Albumin: 2.8 g/dL (decreased)
- Total bilirubin: 1.8 mg/dL (elevated)
- Direct bilirubin: 1.0 mg/dL (elevated)
- ALT: 62 U/L (elevated)
- AST: 86 U/L (elevated)
- Alkaline phosphatase: 246 U/L (elevated)
- LDH: 362 U/L (elevated)

Interventions and Treatment:

1. Patient received supportive care including IV fluids, antiemetics, and pain management
2. Therapeutic thoracentesis performed on 03/30/2025, draining 1200 mL of serosanguinous fluid
3. Liver biopsy performed on 04/02/2025 confirming metastatic adenocarcinoma consistent with lung primary
4. Palliative radiation therapy initiated for symptomatic bony metastases (L3 and right iliac bone) with 3 Gy x 5 fractions
5. Vinorelbine therapy discontinued due to disease progression and poor tolerance
6. Hospice consultation obtained on 04/05/2025
7. Palliative care team involved for symptom management and goals of care discussion

MDT Discussion (04/04/2025): After review of the patient's clinical history, current status, and available treatment options, the multidisciplinary tumor board concluded that Mr. Thompson has exhausted all standard-of-care therapy options with progressive disease after six lines of treatment. His ECOG performance status has declined to 3, and he is experiencing significant symptoms related to disease burden. Comprehensive genomic profiling from recent liver biopsy showed no actionable mutations. The board recommended transition to supportive care with focus on symptom management.

DISCHARGE MEDICATIONS:

1. Morphine sulfate extended-release 30 mg PO q12h
2. Morphine sulfate immediate-release 15 mg PO q4h PRN for breakthrough pain
3. Ondansetron 8 mg PO q8h PRN for nausea
4. Dexamethasone 4 mg PO daily
5. Omeprazole 40 mg PO daily
6. Senna-docusate 2 tablets PO BID
7. Tiotropium 18 mcg inhaled daily
8. Fluticasone/salmeterol 250/50 mcg inhaled BID

9. Albuterol inhaler 2 puffs q4h PRN for shortness of breath
10. Atorvastatin 40 mg PO daily
11. Metoprolol succinate 50 mg PO daily
12. Aspirin 81 mg PO daily
13. Tamsulosin 0.4 mg PO daily

FUNCTIONAL STATUS AT DISCHARGE:

ECOG Performance Status: 3 Patient requires considerable assistance with activities of daily living. He is able to ambulate short distances with walker but spends >50% of waking hours in bed or chair. He requires oxygen supplementation at 2L via nasal cannula with exertion.

DISCHARGE DISPOSITION:

Patient discharged home with hospice services. Family has been instructed on medication management and symptom control measures.

DISCUSSION AND PROGNOSIS:

Mr. Thompson has demonstrated progressive disease after multiple lines of therapy for metastatic NSCLC. Despite initial response to immunotherapy with pembrolizumab for 18 months, subsequent treatments have shown diminishing returns with increasing toxicity. Recent imaging confirms multi-site disease progression with new osseous involvement.

Given his deteriorating performance status, significant symptom burden, and exhaustion of standard therapeutic options, the focus of care has shifted to symptom management and quality of life. The patient and family have been counseled regarding prognosis, which is estimated at 1-2 months. They have elected for hospice care at home and completed advance directives indicating no desire for hospital readmission or resuscitation efforts.

FOLLOW-UP RECOMMENDATIONS:

1. Hospice care to begin immediately upon discharge
2. Palliative radiation therapy to complete remaining 2 fractions as outpatient
3. Primary care provider to be notified of discharge disposition
4. Follow-up with oncology team only if hospice feels specialty consultation needed for symptom management

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These findings and recommendations have been discussed with the patient and his family. They express understanding of the disease status, prognosis, and goals of care moving forward.

Electronically signed by: James Wilson, MD Medical Oncology Board Certification: Medical Oncology NPI: 1234567890 Date: 04/08/2025 14:23

NB: Patient died on 04/23/2025