EVERGREEN HOSPICE SERVICES – DISCHARGE SUMMARY

PATIENT NAME: Thompson, Brenda Sue [ID SYN182]
DATE OF BIRTH: April 14, 1956
DATE OF ADMISSION TO HOSPICE: November 10, 2023
DATE OF DISCHARGE (DECEASED): March 5, 2024
LEVEL OF CARE AT DISCHARGE: General Inpatient Care (at Affiliated Hospice House)
PRIMARY HOSPICE DIAGNOSIS: End-Stage Lung Cancer (ICD-10 C34.91)

REFERRING PHYSICIAN: Dr. V. Wells (Medical Oncology)
HOSPICE MEDICAL DIRECTOR: Dr. L. Martin

SUMMARY OF ONCOLOGIC ILLNESS:
Ms. Thompson was diagnosed with Stage IV Lung Adenocarcinoma on November 5, 2020, presenting with persistent cough and fatigue. Staging revealed a 3.5 cm RML primary lesion, extensive bilateral pulmonary nodules, and bilateral adrenal metastases. Brain MRI negative.

- **Initial Pathology (RML Biopsy):** Moderately differentiated Adenocarcinoma with a mixed **lepidic and solid growth pattern**. Tumor cells were cuboidal to columnar with eosinophilic cytoplasm and enlarged, hyperchromatic nuclei. Necrosis noted focally within solid areas.
- **Immunohistochemistry (IHC):** Positive for TTF-1, Napsin-A, CK7. Negative for P40, CK5/6, GATA3.
- **Molecular/PD-L1:** NGS panel **Wild-Type** (EGFR/ALK/ROS1/BRAF/KRAS etc neg). PD-L1 IHC (22C3) **TPS 20%, CPS 25, IC Score 1**/+.

Treatment History:

1. **First-Line (Nov 27, 2020 – Oct 20, 2021):** Carboplatin/Pemetrexed/Pembrolizumab IV q3wks x 4 cycles -> Pemetrexed/Pembrolizumab maintenance. Achieved Stable Disease initially. Tolerated with Gr 1-2 fatigue. Progression noted with growth of adrenal/lung lesions.
2. **Second-Line (Nov 2021 – Apr 2022):** Docetaxel 75 mg/m2 IV q3wks. Tolerated poorly with Gr 3 neutropenia (req GCSF), Gr 2 neuropathy, significant fatigue. Scans after 4 cycles showed further progression (new liver metastases). Therapy discontinued.
3. **Third-Line (May 2022 – Aug 2022):** Gemcitabine 1000 mg/m2 IV D1, 8 q3wks. Experienced profound fatigue and thrombocytopenia. Minimal clinical benefit. Scans showed continued slow progression. Therapy stopped due to poor tolerance / limited benefit / declining PS (ECOG 3).
4. **Best Supportive Care:** Transitioned Sept 2022. Managed symptomatically outpatient.

HOSPICE COURSE (Nov 10, 2023 – Mar 5, 2024):
Admitted initially to Routine Home Care level due to worsening dyspnea (requiring

continuous O2), severe fatigue (bed-chair bound), anorexia/cachexia, and increasing anxiety. Patient lived with supportive daughter.

- **Symptom Management at Home:** Focused on managing dyspnea (scheduled Morphine Elixir titrated up to 10mg q4h + PRN breakthrough, home O2 increased to 4L NC), anxiety (scheduled Lorazepam 0.5mg TID + PRN), fatigue (energy conservation, HHA support), anorexia (focus on comfort feeds), and constipation (aggressive bowel regimen). Received regular visits from RNCM, HHA, SW, Chaplain.
- **Transition to GIP:** Experienced acute worsening of dyspnea and respiratory distress on March 1, 2024, associated with increased restlessness and anxiety, poorly responsive to increased PRN medications at home. Transferred to affiliated inpatient Hospice House for management of refractory symptoms under General Inpatient (GIP) level of care.
- **Inpatient Hospice Course (Mar 1 – Mar 5):** Managed with continuous subcutaneous Morphine infusion (titrated for dyspnea/restlessness), supplemental oxygen via mask, scheduled Lorazepam SC, and Haloperidol SC PRN agitation/delirium. Secretions managed with positioning and Scopolamine patch. Family remained constantly at bedside receiving support from hospice team. Patient became progressively less responsive.

CIRCUMSTANCES OF DEATH: Patient experienced progressive respiratory failure, became unresponsive with periods of apnea. Passed away peacefully at the Hospice House with her daughter present on March 5, 2024.

BEREAVEMENT CARE PLAN: Initiated for daughter per protocol.