BAY AREA CANCER INSTITUTE

DISCHARGE SUMMARY

PATIENT INFORMATION

- **Name:** Yu Zhingli
- **ID:** SYN201 **AGE/GENDER:** 47F
- **DOB:** 10/08/1977
- **ADMISSION:** 04/05/2025
- **DISCHARGE:** 04/14/2025
- **ATTENDING:** Dr. Harper
- **CONSULTS:** Orthopedic Oncology, Pain Management

PRIMARY DIAGNOSIS Pathologic fracture of right femoral neck in patient with EGFR-mutated NSCLC, status post total hip arthroplasty

ONCOLOGIC BACKGROUND 47-year-old female diagnosed with stage IVA NSCLC in August 2022 after presenting with persistent cough and right hip pain. Initial staging revealed a 3.2 cm left upper lobe mass with multiple bone metastases including spine, ribs, and right proximal femur. Biopsy confirmed adenocarcinoma with EGFR exon 19 deletion. Currently on first-line osimertinib since 09/15/2022 with excellent systemic response and stable bone disease until current fracture.

HISTORY OF PRESENT ILLNESS Patient experienced sudden severe right hip pain after standing from seated position. Unable to bear weight, she presented to emergency department where imaging confirmed pathologic fracture through previously known metastatic deposit in right femoral neck. Patient was admitted for surgical management and pain control with orthopedic oncology consultation.

HOSPITAL COURSE Patient underwent right total hip arthroplasty on 04/06/2025. Intraoperative frozen section confirmed metastatic adenocarcinoma. Procedure was uncomplicated with estimated blood loss of 300 mL. Postoperative course was notable for initial challenging pain control requiring multimodal approach including continuation of pre-admission extended-release morphine, addition of gabapentin for neuropathic component, and patient-controlled analgesia for breakthrough pain.

Physical therapy began on postoperative day 1 with progressive weight-bearing and transfer training. Patient advanced quickly to ambulation with walker by postoperative day 3. Home equipment was arranged including hospital bed, raised toilet seat, and shower chair.

Osimertinib was continued throughout hospitalization without interruption given excellent ongoing response and concerns about disease flare with discontinuation. Planned postoperative radiation to surgical bed was discussed but deferred given excellent clinical response to osimertinib with predominantly sclerotic bone lesions on recent imaging.

PATHOLOGY FINDINGS

- **Specimen:** Right femoral head and neck
- **Gross:** Femoral head (5.0 cm diameter) with attached portion of femoral neck (2.5 cm length). Cut surface shows tan-white firm area (2.8 cm) within femoral neck with extension into head.
- **Microscopic:** Metastatic adenocarcinoma involving trabecular bone with associated fibrosis and necrosis. Tumor cells have moderate nuclear pleomorphism with vesicular chromatin and prominent nucleoli. Areas of osteoblastic reaction surround tumor nests, consistent with treatment response.
- **Immunohistochemistry:**
    - TTF-1: Positive

    - Napsin A: Positive
    - EGFR exon 19 deletion mutant-specific antibody: Positive
- **Margins:** Positive at femoral neck resection margin

IMAGING STUDIES

Radiographs, Right Hip (04/05/2025):

- Displaced subcapital fracture of right femoral neck through area of mixed lytic/sclerotic lesion
- No other acute fractures or dislocations

CT Pelvis without contrast (04/05/2025):

- Confirms right femoral neck fracture through metastatic lesion
- Additional sclerotic lesions in bilateral iliac wings and proximal left femur
- No soft tissue mass

CT Chest/Abdomen/Pelvis with contrast (04/08/2025):

- Primary left upper lobe mass decreased to 1.0 cm (previously 3.2 cm at diagnosis)
- Resolution of previously noted hilar lymphadenopathy
- Multiple bone metastases with increased sclerosis compared to baseline, consistent with treatment response
- No new metastatic lesions
- Right hip prosthesis in good position without complication

DISCHARGE MEDICATIONS

1. Osimertinib 80 mg PO daily (continue without interruption)
2. Morphine ER 30 mg PO q12h
3. Oxycodone 5 mg PO q4h PRN breakthrough pain
4. Gabapentin 300 mg PO TID
5. Acetaminophen 1000 mg PO q8h scheduled × 1 week
6. Aspirin 81 mg PO daily
7. Pantoprazole 40 mg PO daily
8. Sennosides-docusate 2 tablets PO daily
9. Denosumab 120 mg SC every 4 weeks (next dose due 04/25/2025)
10. Calcium + Vitamin D supplement daily

DISCHARGE INSTRUCTIONS

1. Weight-bearing as tolerated with walker
2. Hip precautions for 6 weeks (no flexion >90°, no internal rotation past neutral, no adduction past midline)
3. Home physical therapy 3 times weekly for 2 weeks, then outpatient
4. Wound care: Keep incision clean and dry, no soaking for 2 weeks
5. Signs of infection: Report fever >101°F, increasing pain, redness, swelling, or drainage

FOLLOW-UP APPOINTMENTS

1. Orthopedic Surgery: 04/21/2025
2. Medical Oncology: 04/28/2025
3. Physical Therapy: Home visits to start 04/16/2025
4. Imaging: Next disease assessment CT scheduled for 06/15/2025

DISCHARGE CONDITION Patient is stable, afebrile, with pain controlled on current regimen. Surgical site shows appropriate healing without signs of infection. Patient is able to transfer independently and ambulate with walker for 50 feet. Neurovascularly intact distally. ECOG performance status 2 (from baseline 1).

PROGNOSIS Favorable near-term prognosis given excellent ongoing response to targeted therapy. Pathologic fracture represents local complication and no disease progression. Expected functional recovery within 4-6 weeks.

Electronically signed by:
Elizabeth Harper, MD
Medical Oncology
04/14/2025 15:40