Oncology Clinic Visit Summary

PATIENT: Downey, Frank
MRN: SYN093

BORN: 04/01/1956
DATE OF VISIT: August 10, 2022
PROVIDER: Kenji Tanaka, MD

REASON FOR VISIT: Discuss results of recent surveillance imaging indicating disease progression after prolonged response to Pembrolizumab. Formulate plan for second-line therapy.

ONCOLOGIC HISTORY: Mr. Downey was diagnosed with Stage IV NSCLC (Squamous Cell Carcinoma confirmed on brain biopsy) in May 2020 after presenting with headaches and subtle cognitive changes. Brain MRI revealed multiple enhancing metastatic lesions (largest 2cm L frontal, 1.5cm R parietal) with surrounding edema. Staging PET/CT was otherwise negative for distant metastatic disease, but showed a hypermetabolic primary lesion in the RUL (3cm) and mediastinal lymphadenopathy. PD-L1 IHC (22C3) was strongly positive: **TPS 95%, CPS 100, IC Score 3/+**. NGS panel was Wild-Type.

- **Initial Management:** Underwent Stereotactic Radiosurgery (SRS) to brain metastases (May 2020). Started first-line **Pembrolizumab 200 mg IV q3 weeks on June 3, 2020**.
- **Response:** Experienced an excellent response both intracranially (complete resolution on subsequent MRIs) and systemically (near-complete resolution of primary lung lesion and mediastinal nodes). Maintained this response with good quality of life (ECOG 0) and minimal toxicity (Grade 1 fatigue only) for an extended period.

RECENT EVENTS: Patient remained stable on Pembrolizumab q3 weeks. Surveillance imaging performed late July 2022 revealed evidence of progression.

- **Imaging (July 28, 2022):**
    - **Brain MRI:** Stable post-SRS changes. **No evidence of intracranial progression.**
    - **CT Chest/Abdomen/Pelvis:** Compared to April 2022. Definite regrowth of the primary RUL lesion (now 2.5 cm, previously <1cm). Re-emergence and enlargement of previously resolved mediastinal lymph nodes (subcarinal now 1.8cm). Development of several **new** small pulmonary nodules bilaterally (<8mm). No new distant metastases below diaphragm.
- **Progression Timing:** Progression noted after Pembrolizumab therapy. Last dose was mid-July 2022.

SUBJECTIVE (Today): Patient reports feeling well overall. He had noticed a slight increase in a mild, intermittent cough over the past month but didn't think much of it. Denies dyspnea, chest pain, hemoptysis, fatigue, weight loss, or neurological symptoms. Aware of scan results showing progression. Remains active, ECOG 0-1.

OBJECTIVE: Vitals stable. Exam unremarkable. Labs (CBC/CMP) WNL.

ASSESSMENT:

1. **Stage IV Squamous Cell Lung Carcinoma (WT, PD-L1 High):** Disease progression noted systemically (primary lung lesion, mediastinal nodes, new lung nodules) after an excellent and prolonged response to first-line Pembrolizumab monotherapy. Importantly, intracranial disease remains controlled post-SRS. Patient remains in excellent PS and is suitable for second-line treatment.

PLAN:

1. **Discontinue Pembrolizumab.**
2. **Second-Line Therapy Discussion:** Standard options for squamous cell carcinoma progressing after first-line immunotherapy reviewed:
    - **Platinum-Doublet Chemotherapy:** Carboplatin + Paclitaxel (or nab-Paclitaxel) is a standard. Gemcitabine + Cisplatin/Carboplatin also an option.
    - **Docetaxel +/- Ramucirumab:** Ramucirumab approved with Docetaxel in squamous histology post-platinum therapy, less clear role post-IO alone, but Docetaxel itself is a standard second/later line option.
    - **Clinical Trial:** Always a consideration.
    - **Rationale:** Given the squamous histology and progression after IO, platinum-based doublet is generally preferred next step. Carboplatin/Paclitaxel is a common standard.
3. **Shared Decision:** Patient agreeable to proceeding with chemotherapy. Prefers Carboplatin/Paclitaxel regimen.
4. **Initiate Chemotherapy:**
    - **Regimen:** Carboplatin (AUC 5-6) + Paclitaxel (175-200 mg/m2) IV every 3 weeks for 4-6 cycles, then reassess (potential for maintenance debated in squamous, often observe).
    - **Schedule:** Target C1D1 within 1-2 weeks, pending insurance auth.
    - **Supportive Care:** Pre-meds for taxane hypersensitivity (Dexamethasone, H1/H2 blockers). Anti-emetics (NK1 antagonist + 5HT3 antagonist + Dex). G-CSF support likely needed. Educated on neuropathy, alopecia, myelosuppression, fatigue.
5. **Monitoring:** Labs (CBC, CMP) prior to each cycle. Restaging CT C/A/P after 2-4 cycles. Continue Brain MRI surveillance q3-6 months.
6. **Follow-up:** Clinic nursing to schedule C1D1. Return for assessment prior to C2.

_____ M.D.
Kenji Tanaka, MD (Electronically Signed)