Memorial Cancer Pavilion - Medical Oncology
Consultation Note - Second Opinion

Date of Service: August 21, 2021
Patient: Jones, Samuel David ("Sam")
MRN: SYN025 **DOB:** 03/09/1956
Consultant: Dr. Vivian Wells, MD
Referring Physician: Dr. Robert Greene (Community Oncology)

REASON FOR CONSULTATION: Request for second opinion regarding management options for Stage IV Lung Adenocarcinoma following confirmed progression on first-line chemo-immunotherapy.

HISTORY PROVIDED (From Records & Patient Interview):
Mr. Jones is a 65-year-old gentleman diagnosed with Stage IV Lung Adenocarcinoma on July 1, 2020. Initial presentation was fatigue and vague upper abdominal discomfort. Staging CT C/A/P revealed a 3 cm LUL primary lesion, minor mediastinal nodes, and multiple large hepatic metastases (dominant lesion 6 cm in segment VIII, others up to 3 cm). Brain MRI negative. Liver biopsy confirmed metastatic adenocarcinoma, lung primary favored (TTF-1+).

- **Molecular/PD-L1 (July 2020):** Comprehensive NGS panel was **Wild-Type** for common drivers (EGFR/ALK/ROS1/BRAF/KRAS/MET/RET). PD-L1 IHC (22C3): **TPS 25%, CPS 30, IC Score 1/+**.
- **First-Line Therapy:** Commenced **Carboplatin (AUC 5) / Pemetrexed (500 mg/m2) / Pembrolizumab (200 mg) q3 weeks starting July 24, 2020**. Completed 4 cycles induction, followed by maintenance Pemetrexed/Pembrolizumab.
- **Response & Progression:** Achieved initial partial response with >50% reduction in size of liver metastases. Maintained this response/stable disease until approximately June 2021 (~11 months total duration). Surveillance CT C/A/P on June 28, 2021 demonstrated unequivocal progression with significant increase in size of all previously known hepatic metastases (dominant lesion now 8.5 cm) and appearance of several new hepatic lesions. Lung primary and nodes remained relatively stable. Last dose of Pem/Pembro maintenance was June 10, 2021.

Patient presents today accompanied by his wife to discuss options. He reports increased fatigue over the past month and intermittent RUQ ache, managed with Tylenol. No jaundice. Appetite fair. Performance status remains good (ECOG 1). He tolerated the first-line regimen reasonably well, main toxicities were Grade 1-2 fatigue, mild anemia (Hgb nadir 10.5), and Grade 1 sensory neuropathy (resolved off carboplatin).

PAST MEDICAL HISTORY:

- Osteoarthritis (knees)
- Benign Prostatic Hyperplasia (BPH)
- Hypertension (on Ramipril)
- History of smoking (35 pack-years, quit 2005)

CURRENT MEDICATIONS (as reported):

- Ramipril 10 mg PO Daily
- Tamsulosin 0.4 mg PO Daily

- Acetaminophen 500-1000 mg PO PRN pain
- Folic Acid 1 mg Daily (recently stopped)
- Multivitamin

OBJECTIVE:

- Vitals: T 37.1, BP 132/80, HR 72, SpO2 98% RA. ECOG 1.
- Exam: Alert, appears stated age. No scleral icterus. Lungs clear. Cor: RRR. Abd: Soft, mild RUQ tenderness to deep palpation, no definite hepatomegaly appreciated. No edema.

REVIEW OF RECORDS/IMAGING: Reviewed outside records from Dr. Greene and recent CT report from June 28, 2021 confirming progression primarily in the liver.

ASSESSMENT:
Mr. Jones is a 65 y/o male with Stage IV WT Lung Adenocarcinoma, PD-L1 TPS 25%, who experienced disease progression (primarily hepatic) after ~11 months of benefit from first-line Carboplatin/Pemetrexed/Pembrolizumab. He remains in good performance status (ECOG 1) and is motivated for further therapy.

DISCUSSION & RECOMMENDATIONS:
Reviewed the natural history of the disease and standard second-line treatment options in this setting:

1. **Docetaxel Monotherapy:** A standard cytotoxic chemotherapy option. Efficacy modest, potential for significant toxicity (neutropenia, fatigue, neuropathy, alopecia, fluid retention).
2. **Docetaxel + Ramucirumab (Anti-VEGFR2 Antibody):** Phase III trial (REVEL) showed statistically significant improvement in OS vs Docetaxel alone (median OS 10.5 vs 9.1 months). Adds specific toxicities (hypertension, bleeding risk, proteinuria). Requires q3 week infusion.
3. **Gemcitabine Monotherapy:** Alternative chemotherapy, different side effect profile (more myelosuppression, flu-like symptoms). Efficacy generally considered similar or slightly less than Docetaxel.
4. **Clinical Trials:** Discussed potential eligibility for trials, although options for WT, post-chemo/IO may be limited. Offered to screen if interested.
5. **Best Supportive Care:** Always an option, focus solely on symptom management. Not preferred by patient at this time.

Patient Preferences: After detailed discussion of risks, benefits, logistics, and side effects of Docetaxel +/- Ramucirumab, Mr. Jones and his wife expressed preference for the **Docetaxel + Ramucirumab** combination, acknowledging the potential for increased toxicity but hoping for the maximal potential efficacy benefit.

Recommendations to Dr. Greene / Plan:

1. Agree with proceeding to second-line therapy.
2. Recommend initiating Docetaxel (75 mg/m2) + Ramucirumab (10 mg/kg) IV every 3 weeks.
3. **Supportive Care:**

    - Standard Docetaxel pre-medication (Dexamethasone 8mg PO BID x 3 days starting day prior).
    - Prophylactic G-CSF support (e.g., Pegfilgrastim day after chemo) strongly recommended due to Docetaxel myelosuppression risk.
    - Monitor blood pressure closely due to Ramucirumab (may need adjustment of Ramipril). Baseline urinalysis for protein.
    - Antiemetics PRN (e.g., Ondansetron/Prochlorperazine).
4. **Monitoring:** Clinical assessment and labs (CBC, CMP, U/A) prior to each cycle. Restaging CT C/A/P after 2-3 cycles (6-9 weeks).
5. Happy to co-manage or provide further consultation as needed. Thank you for the opportunity to see Mr. Jones.

_____ M.D.
Vivian Wells, MD (Electronically Signed)
Medical Oncology