Thoracic Oncology Tumor Board - Case Presentation

Case: SYN078 (Kubrick, Stanley) - Retrospective Review / Outcome Analysis
Date Presented: September 5, 2020
Presenter: Dr. Robert Greene (Community Oncology)

Patient Demographics: 72 y/o Male (DOB June 6, 1948)
Diagnosis Date: Sept 9, 2019
Diagnosis: Stage IV Lung Adenocarcinoma
Presenting Symptoms: Jaundice, RUQ pain

Staging:

- Primary: RLL nodule (small)
- Metastases: Liver (extensive, causing biliary obstruction), Mediastinal LNs.
- Brain MRI: Negative.

Pathology/Molecular:

- Histology: Adenocarcinoma (Liver Bx)
- Molecular: NGS **Wild-Type** (EGFR/ALK/ROS1/BRAF/KRAS/MET/RET Neg)
- PD-L1 (22C3): **TPS 0%**, CPS <5, IC 0

Comorbidities: HTN, Gout. Former Smoker (25 ppy, quit long ago).

Treatment Course:

- **Pre-Treatment:** ERCP + Biliary Stent placed (Sept 2019) due to obstruction.
- **First-Line Therapy:** Carboplatin (AUC 6) + Paclitaxel (175 mg/m2 initial) q3wks.
    - *Start Date:* Sept 30, 2019
    - *Tolerance:* POOR. Gr 3 Neutropenia (req GCSF), Gr 2/3 Neuropathy (Paclitaxel dose reduced), Significant Fatigue.
    - *Response:* Minimal / Stable Disease after 3 cycles.
    - *Progression:* Rapid progression noted after Cycle 5 (Scan Feb 2020). Enlarging Liver Mets, worsening biliary dilation, new Pulm/Adrenal Mets.
- **Second-Line Therapy:** NOT administered due to rapid decline post-1L, poor PS (ECOG 3), significant residual toxicity (neuropathy).
- **Transition to Best Supportive Care:** Feb 2020. Managed by Oncology/Palliative Care outpatient.

Outcome:

- Progressive decline due to hepatic failure (worsening jaundice, ascites, encephalopathy).
- Final Admission: Aug 20, 2020 (Hepatic failure, delirium, AKI, respiratory distress).
- Goals of Care: Comfort Measures Only.
- **Date of Death:** August 25, 2020

Key Learning Points / Discussion:

- Illustrates aggressive nature of some WT, PD-L1 negative lung adenocarcinomas, particularly with high hepatic burden at presentation.
- Poor tolerance to standard Carboplatin/Paclitaxel chemotherapy significantly limited treatment options and duration.
- Rapid progression after short PFS on first-line chemo portends poor prognosis.
- Importance of early palliative care integration in patients with high symptom burden and poor prognostic features.
- Question for discussion: Would alternative chemo (e.g., Carbo/Pem if histology clearer initially?) have been better tolerated, or outcome likely similar given aggressive biology?