PALLIATIVE CARE UNIT

SUNRISE MEMORIAL HOSPITAL

DISCHARGE SUMMARY

DATE: April 10, 2025

- **ADMISSION DATE:** 04/03/2025
- **DISCHARGE DATE:** 04/10/2025
- **ADMITTING PHYSICIAN:** Dr. Michael Rivera
- **DISCHARGING PHYSICIAN:** Dr. Michael Rivera

PATIENT INFORMATION:

- **NAME:** Harold Johnson
- **MRN:** SYN089
- **DOB:** 10/04/1949

DIAGNOSIS AT DISCHARGE:

1. Metastatic non-small cell lung cancer (adenocarcinoma), wild-type, with progression on multiple lines of therapy
2. Terminal respiratory failure due to progressive lung disease
3. Malignant bilateral pleural effusions
4. Cachexia
5. Chronic kidney disease, stage 3
6. Chronic obstructive pulmonary disease
7. Hypertension
8. Coronary artery disease

BRIEF HISTORY: Mr. Johnson was a 75-year-old male with stage IV wild-type NSCLC diagnosed in December 2019. He initially presented with dyspnea, cough, and weight loss and was found to have multiple bilateral pulmonary nodules with a dominant 4.2 cm right upper lobe mass. He received multiple lines of therapy over approximately 5 years but experienced disease progression and declining functional status over the past 3 months. He was admitted to the palliative care unit for management of progressive dyspnea, pain, and declining functional status. The goals of admission were symptom management and transition to hospice care.

DETAILED ONCOLOGIC HISTORY:

Date of Diagnosis: December 27, 2019

Presenting Symptoms: Persistent cough, dyspnea on exertion, 20-pound weight loss over 3 months

Initial Staging Work-up:

- CT Chest (12/20/2019): 4.2 cm right upper lobe mass with multiple bilateral pulmonary nodules consistent with intrapulmonary metastases
- PET/CT (12/23/2019): Hypermetabolic right upper lobe mass (SUVmax 14.2), multiple hypermetabolic pulmonary nodules, mild FDG uptake in mediastinal nodes
- CT-guided biopsy of right upper lobe mass (12/27/2019): Non-small cell lung adenocarcinoma, moderately differentiated
- Brain MRI (12/26/2019): Negative for intracranial metastases

Molecular Testing:

- EGFR, ALK, ROS1, BRAF, MET, RET, NTRK: All negative/wild-type
- KRAS: Wild-type
- PD-L1 (22C3): TPS <1% (0%), CPS <1%, IC <1%

Initial Staging: cT2bN1M1a (Stage IVA) with intrapulmonary metastases

Treatment History:

1. **First-line therapy:** Carboplatin AUC 5 D1 + Pemetrexed 500 mg/m² D1 + Pembrolizumab 200 mg D1, q3 weeks
    - Started: January 20, 2020
    - Duration: 8 months
    - Best response: Partial response (40% reduction in primary tumor)
    - End date: September 2020
    - Reason for discontinuation: Disease progression
2. **Second-line therapy:** Docetaxel 75 mg/m² q3 weeks
    - Started: October 2020
    - Duration: 4 months
    - Best response: Stable disease
    - End date: February 2021
    - Reason for discontinuation: Disease progression
3. **Third-line therapy:** Gemcitabine 1000 mg/m² D1, D8 q3 weeks
    - Started: March 2021
    - Duration: 5 months
    - Best response: Partial response
    - End date: August 2021
    - Reason for discontinuation: Disease progression
4. **Fourth-line therapy:** Nivolumab 240 mg q2 weeks
    - Started: September 2021
    - Duration: 3 months
    - Best response: Progressive disease
    - End date: December 2021
    - Reason for discontinuation: Disease progression
5. **Fifth-line therapy:** Vinorelbine 25 mg/m² weekly

    - Started: January 2022
    - Duration: 6 months
    - Best response: Stable disease
    - End date: July 2022
    - Reason for discontinuation: Disease progression and declining performance status
6. **Sixth-line therapy:** Clinical trial of investigational PARP inhibitor + temozolomide
    - Started: August 2022
    - Duration: 4 months
    - Best response: Progressive disease
    - End date: December 2022
    - Reason for discontinuation: Disease progression
7. **Supportive care only:** December 2022 - Present

Palliative Interventions:

- Right-sided therapeutic thoracentesis × 4 (most recent: January 2025)
- Left-sided therapeutic thoracentesis × 3 (most recent: February 2025)
- Palliative radiation to painful right rib metastases (November 2023)

PAST MEDICAL HISTORY:

1. Chronic obstructive pulmonary disease (40 pack-year smoking history, quit 2015)
2. Coronary artery disease with previous stent placement (2016)
3. Hypertension
4. Chronic kidney disease stage 3
5. Type 2 diabetes mellitus
6. Benign prostatic hyperplasia
7. Osteoarthritis

PAST SURGICAL HISTORY:

1. Coronary stent placement (2016)
2. Appendectomy (1970)
3. Right inguinal hernia repair (1995)

SOCIAL HISTORY: Retired construction worker. Widowed (wife deceased 2018). Two adult children, daughter lives locally. Former smoker (40 pack-years, quit 2015). Occasional alcohol use until diagnosis. No recreational drug use.

HOSPITAL COURSE:

Mr. Johnson was admitted to the palliative care unit with progressive dyspnea, severe fatigue, anorexia, and pain. Initial assessment revealed hypoxemia requiring 4L oxygen via nasal cannula, cachexia (weight 58 kg, down from 75 kg at diagnosis), and bilateral pleural effusions on chest X-ray.

The focus of care was on symptom management rather than disease-modifying therapy, in accordance with the patient's previously expressed wishes. Goals of care discussions were held with the patient and family, with consensus that comfort-focused care was most appropriate given the extensive disease progression and exhaustion of standard treatment options.

Respiratory symptoms were managed with scheduled morphine, supplemental oxygen, and as-needed nebulized bronchodilators. The patient had previously declined indwelling pleural catheters, preferring intermittent thoracentesis as needed for symptomatic relief. Due to his overall clinical decline, further thoracentesis was not performed during this admission.

Pain was initially poorly controlled but improved significantly with titration of extended-release morphine and breakthrough immediate-release morphine. By day 3, pain was well-controlled on the established regimen.

Anxiety was treated with scheduled lorazepam with good effect. Spiritual care services were engaged at the patient's request.

Nutritional status remained poor despite dietary consultation and family-provided favorite foods. This was recognized as part of the terminal disease process, and artificial nutrition was not pursued in accordance with the patient's advance directive.

The patient experienced gradual functional decline during the hospitalization but remained alert and able to engage with family until approximately 36 hours before discharge. Terminal delirium was managed with haloperidol as needed.

Hospice services were arranged, with acceptance into an inpatient hospice facility for continued end-of-life care.

PHYSICAL EXAMINATION AT DISCHARGE:

Vital Signs:

- Temperature: 36.7°C
- Heart Rate: 92 bpm
- Blood Pressure: 112/68 mmHg
- Respiratory Rate: 22/min, shallow
- Oxygen Saturation: 92% on 4L oxygen via nasal cannula

General: Elderly male appearing chronically ill and cachectic. Minimally responsive to voice and touch.

HEENT: Normocephalic. Dry mucous membranes. Sclera anicteric.

Cardiovascular: Regular rhythm, tachycardic. No murmurs, rubs, or gallops appreciated.

Respiratory: Decreased breath sounds bilaterally with dullness to percussion at bases. Scattered crackles throughout.

Abdominal: Scaphoid, soft, non-tender. Hypoactive bowel sounds.

Extremities: Cool to touch. Trace bilateral lower extremity edema. No cyanosis.

Skin: Pale with poor turgor. Pressure ulcer stage II on sacrum (2 cm x 2 cm).

Neurological: Somnolent, arousable to voice but quickly returns to sleep. Pupils equal and reactive. No focal deficits observed.

DIAGNOSTIC STUDIES:

Laboratory Data (04/03/2025):

- Complete Blood Count:
  - WBC: 12.8 × 10^9/L (elevated)
  - Hemoglobin: 9.2 g/dL (low)
  - Platelets: 132 × 10^9/L (low)
- Comprehensive Metabolic Panel:
  - Sodium: 134 mmol/L
  - Potassium: 4.6 mmol/L
  - Chloride: 99 mmol/L
  - CO_2: 28 mmol/L (elevated)
  - BUN: 42 mg/dL (elevated)
  - Creatinine: 1.8 mg/dL (elevated from baseline 1.5)
  - Glucose: 156 mg/dL
  - Calcium: 8.8 mg/dL
  - Albumin: 2.6 g/dL (low)
  - Total protein: 5.8 g/dL (low)
  - AST: 48 U/L (mildly elevated)
  - ALT: 32 U/L
  - Alkaline phosphatase: 186 U/L (elevated)
  - Total bilirubin: 0.9 mg/dL

Imaging Studies:

Chest X-ray (04/03/2025): Extensive bilateral pulmonary nodular opacities significantly increased from prior studies. Large bilateral pleural effusions. Right upper lobe mass approximately 6.2 cm (increased from 5.5 cm in January 2025). Cardiomegaly.

No additional imaging studies were performed due to palliative focus of care.

DISCHARGE MEDICATIONS:

1. Morphine sulfate extended-release 30 mg PO q12h
2. Morphine sulfate immediate-release 10 mg PO/SL q4h PRN breakthrough pain or dyspnea

3. Lorazepam 0.5 mg SL q6h scheduled and q2h PRN anxiety
4. Haloperidol 0.5 mg PO/SL q4h PRN agitation or terminal delirium
5. Scopolamine patch 1.5 mg q72h for secretions
6. Senna 8.6 mg PO BID
7. Docusate sodium 100 mg PO BID
8. Bisacodyl 10 mg PR daily PRN constipation
9. Metoprolol succinate 25 mg PO daily

Note: All medications to be managed by inpatient hospice facility according to their protocols.

DISCHARGE DISPOSITION: Transfer to inpatient hospice facility

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DISCHARGE INSTRUCTIONS:

1. Comfort care only
2. DNR/DNI status confirmed
3. Continue oxygen therapy for comfort
4. Medication administration per hospice protocols
5. Family visits permitted 24/7

ADVANCE DIRECTIVES: The patient has a completed advance directive on file indicating:

- DNR/DNI status
- No artificial nutrition or hydration
- No cardiopulmonary resuscitation
- No ICU admission
- Comfort measures only The patient's daughter is named as healthcare proxy.

PROGNOSIS: Mr. Johnson has end-stage metastatic NSCLC with disease progression on six lines of therapy and a current ECOG performance status of 4. His overall prognosis is poor with an estimated survival of days to weeks based on clinical presentation, including:

- Cachexia with >30% weight loss from baseline
- Progressive respiratory failure requiring increasing oxygen
- Declining level of consciousness
- Minimal oral intake
- Declining renal function
- Progressive disease on imaging

FOLLOW UP: Patient died on April 16, 2025

Electronically signed by:
Michael Rivera, MD
Palliative Care Medicine
Sunrise Memorial Hospital
April 10, 2025 11:45