Oncology end-of-life summary note

evergreen oncology associates - patient record summary

patient: fryker, morgan porterfield born 12/18/1956

date of diagnosis: november 16, 2020
date of death: december 12, 2022 (age 65)

patient-id: SYN123

final diagnosis: metastatic lung adenocarcinoma (kras g12v positive)

oncologic history summary:
mr. fryker, a 64-year-old gentleman at diagnosis with a history of copd and prior smoking (40 pack-years, quit 10 yrs prior), presented in november 2020 with persistent cough and weight loss. staging workup revealed a 4.8 cm lul primary mass, extensive mediastinal lymphadenopathy, multiple bilateral pulmonary nodules, and numerous bilobar hepatic metastases. brain mri was negative at diagnosis. biopsy confirmed adenocarcinoma. molecular testing identified a **kras g12v mutation**. pd-l1 expression (ihc 22c3) was **negative (tps 0%, cps <5, ic 0)**.

treatment trajectory:

1. **first-line therapy (dec 2020 - oct 2021):** initiated standard first-line **carboplatin (auc 5) + pemetrexed (500 mg/m2) + pembrolizumab (200 mg) iv q3 weeks** starting dec 8, 2020 (despite pd-l1 neg status, per guideline options at the time including chemo-io). completed 4 cycles induction, followed by pemetrexed/pembrolizumab maintenance.
    - *response:* achieved initial stable disease with minor shrinkage of liver lesions. tolerated reasonably well (gr 1-2 fatigue, mild nausea).
    - *progression:* disease progression noted on ct scans oct 5, 2021 (approx. **10 months pfs**) with significant enlargement of hepatic metastases and increased pulmonary nodule burden.
2. **second-line therapy (oct 2021 - mar 2022):** started **docetaxel 75 mg/m2 iv q3 weeks**.
    - *tolerability:* experienced significant grade 3 neutropenia (requiring pegfilgrastim), worsening grade 2 fatigue, and development of grade 2 peripheral neuropathy.
    - *response:* restaging after 3 cycles showed mixed response/stable disease. continued therapy cautiously with dose reduction (60 mg/m2). scans in mar 2022 (~5 months on docetaxel) showed **further progression** in liver and lungs, development of new adrenal metastases. performance status declined to ecog 2. docetaxel discontinued.
3. **third-line therapy discussion / supportive care transition (apr 2022):** given progression through standard 1l/2l therapies, kras g12v mutation (no approved targeted therapy), and declining performance status/cumulative toxicity, further systemic therapy options were limited and offered low likelihood of benefit. extensive goals of care discussion held with patient and family. patient expressed fatigue with treatment burden and wished to focus on quality of life. declined clinical trial participation. decision made to

transition to **best supportive care** focus. referred formally to outpatient palliative care clinic.

4. **palliative / end-of-life phase (may 2022 - dec 2022):** managed supportively for increasing symptoms:
    - *pain:* developed ruq pain from liver mets, managed initially with tramadol, later required transition to long-acting morphine (ms contin) + breakthrough hydromorphone.
    - *dyspnea:* developed progressive exertional dyspnea, managed with home oxygen and low-dose morphine elixir prn.
    - *cachexia/anorexia:* significant weight loss, poor appetite despite trial of megestrol acetate.
    - *performance status:* progressively declined to ecog 3-4 (mostly bed/chair bound) by fall 2022.
    - *hospice:* enrolled with community home hospice services in november 2022 due to continued decline and increasing care needs exceeding family's ability at home without formal support.

terminal event: experienced rapid decline in final week, admitted briefly to hospice inpatient unit for management of delirium and uncontrolled restlessness. passed away peacefully at the hospice facility on december 12, 2022.

summary prepared by: k. tanaka, md (medical oncology), December 12, 2022