**Admission Date:** N/A (Outpatient Encounter Note)
**Discharge Date / Date of Note:** 2022-08-25

**Attending Physician:** Dr. Evelyn Reed, MD (Oncology)
**Consulting Services:** Pulmonology (Dr. A. Sharma), Interventional Radiology (Dr. C. Jones)

**Discharge Diagnoses:**

1. Metastatic Non-Small Cell Lung Cancer (NSCLC), Adenocarcinoma subtype, primary right lower lobe. Stage IVB (pT2aN0M1c).
    - Wild-Type (WT) for EGFR, ALK, ROS1, BRAF V600E. KRAS negative.
    - PD-L1 Tumor Proportion Score (TPS): 65% (Positive)
    - Metastatic site: Left adrenal gland.
    - Progressive disease after first-line immunotherapy.
2. Chronic Obstructive Pulmonary Disease (COPD), GOLD Stage II.
3. Hypertension, controlled.
4. History of Tobacco Use (40 pack-years, quit 2019).

**Reason for Recent Evaluation / Summary of Clinical Course:**
Mr. Grusnik is a 65-year-old male with a history of COPD and hypertension, diagnosed in November 2020 with metastatic NSCLC. He initially presented with persistent flank pain and fatigue. Workup including CT Chest/Abdomen/Pelvis revealed a 3.5 cm spiculated mass in the right lower lobe and a concerning 4.2 cm left adrenal mass. Bronchoscopy with EBUS-TBNA was negative for nodal involvement (N0). CT-guided biopsy of the adrenal mass on 2020-11-27 confirmed metastatic adenocarcinoma, consistent with lung primary. Molecular testing revealed WT status for common drivers. Crucially, immunohistochemistry demonstrated high PD-L1 expression with a TPS of 65%.

Given the high PD-L1 expression and patient performance status (ECOG 1), he was initiated on first-line single-agent Pembrolizumab 200 mg IV every 3 weeks, starting 2020-12-18. He tolerated treatment exceptionally well initially, with only Grade 1 fatigue reported. He experienced a significant partial response on imaging.

**Pertinent Laboratory Data (Selected Trends):**

- **Baseline (Dec 2020):** WBC 8.2, Hgb 13.1, Plt 280k. Creatinine 1.0 mg/dL, ALT 25 U/L, AST 30 U/L, Alk Phos 95 U/L, TSH 2.1 mIU/L. CEA 15.2 ng/mL.
- **During Therapy (Peak Response - Approx. Aug 2021):** WBC 7.5, Hgb 13.5, Plt 250k. Creatinine 0.9 mg/dL, ALT 28 U/L, AST 33 U/L. TSH monitored q12 weeks, remained euthyroid. CEA decreased to 4.1 ng/mL.
- **Recent (Aug 2022):** WBC 9.1, Hgb 11.8 (mild normocytic anemia), Plt 310k. Creatinine 1.1 mg/dL, ALT 45 U/L, AST 52 U/L (mild elevation). TSH 2.5 mIU/L. CEA increased to 28.5 ng/mL.

**Pertinent Imaging / Pathology Findings:**

- **Pathology (Adrenal Biopsy 2020-11-27):** Metastatic Adenocarcinoma. IHC: TTF-1 positive, Napsin-A positive. PD-L1 IHC 22C3 pharmDx: TPS 65%. Molecular: EGFR/ALK/ROS1/BRAF neg; KRAS neg.
- **Baseline CT CAP (2020-11-15):** 3.5 cm RLL mass; 4.2 cm left adrenal mass. No other distant mets.
- **CT CAP (2021-08-10 - Maximal Response):** RLL mass decreased to 1.8 cm (stable scar vs residual); Left adrenal mass decreased to 1.5 cm. No new sites of disease. RECIST v1.1 Partial Response.
- **CT CAP (2022-08-18 - Progression):** RLL mass stable at 1.9 cm. Left adrenal mass increased to 3.8 cm. New sub-centimeter hepatic lesion (Segment VI, 0.9 cm) and mildly enlarged retroperitoneal lymph node (1.2 cm short axis). Overall RECIST v1.1 Progressive Disease.

**Hospital Course / Treatment Summary (Outpatient Context):**
Mr. Grusnik received Pembrolizumab monotherapy from 2020-12-18 to 2022-08-08. He maintained good quality of life and ECOG PS 1 for the majority of this period. His treatment was complicated only by mild fatigue and occasional Grade 1 pruritus managed with topical steroids. Routine surveillance imaging consistently showed response or stability until the most recent scan on 2022-08-18, which unfortunately demonstrated clear disease progression in the adrenal gland and development of new metastatic sites in the liver and retroperitoneal nodes, consistent with the rise in CEA. This progression occurred after 20 months of initial therapy.

Today's visit was focused on reviewing these results and discussing next steps. The patient remains ECOG PS 1, though notes increased fatigue over the past month. We discussed second-line treatment options, primarily chemotherapy. Standard options include Docetaxel +/- Ramucirumab or Pemetrexed (if not previously given, though less likely given adenocarcinoma histology usually sees pemetrexed earlier). Given his adenocarcinoma histology and prior immunotherapy exposure, Docetaxel plus Ramucirumab is a preferred option. We discussed the potential toxicities including myelosuppression, fatigue, neuropathy, hypertension (Ramucirumab-specific), and infusion reactions. Alternatives like single-agent Docetaxel were also reviewed. Clinical trial options were explored but none are immediately accessible/suitable.

The patient understands the rationale for changing therapy due to progression. He wishes to proceed with second-line Docetaxel/Ramucirumab. Pre-chemotherapy labs have been drawn today, and he is scheduled to start Cycle 1 Day 1 in approximately one week, pending insurance authorization.

**Condition at Discharge:** Stable. ECOG PS 1. Understands diagnosis, prognosis, and treatment plan.

**Discharge Medications:**

- Pembrolizumab - DISCONTINUED.
- Amlodipine 10 mg daily (Hypertension)
- Tiotropium inhaler 1 puff daily (COPD)
- Albuterol MDI 1-2 puffs q4-6h PRN shortness of breath (COPD)
- Loratadine 10 mg daily PRN pruritus
- Aprepitant, Ondansetron, Dexamethasone regimen to be provided with chemotherapy initiation.

**Discharge Instructions / Follow-Up Plan:**

1. Follow up with Dr. Reed in Oncology clinic in 1 week for initiation of second-line chemotherapy (Docetaxel/Ramucirumab). Call office immediately for fever > 100.4 F, chills, severe nausea/vomiting, shortness of breath, chest pain, or signs of bleeding/bruising after starting chemo.
2. Continue current medications for COPD and Hypertension as prescribed.

3. Maintain adequate hydration and nutrition.
4. Follow up with Pulmonology (Dr. Sharma) as scheduled (next appt in 3 months).
5. Routine labs (CBC, CMP) to be checked prior to each chemotherapy cycle.
6. Repeat staging CT scans after 2-3 cycles of chemotherapy (approx. 6-9 weeks).

**Diet:** Regular, encourage high protein/calorie intake.
**Activity:** As tolerated, maintain light activity (e.g., walking) as able.

**Prognosis:** Guarded, given progression after first-line immunotherapy. Response to second-line therapy is variable.

**Electronically Signed By:**
Dr. Evelyn Reed, MD
Date/Time: 2022-08-25 16:30

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**Patient Name:** Aleksandr Grusnik
**Medical Record Number:** SYN221
**Date of Birth:** 1957-11-18