Metropolitan General Hospital - Discharge Summary

PATIENT: Finch, Harold Edgar
MRN: SYN 023 **DOB:** 1951-06-27
GENDER: Male
ATTENDING: Dr. Anya Sharma (Hospital Medicine)
CONSULTING: Dr. Kenji Tanaka (Medical Oncology), Palliative Care

DATE OF ADMISSION: 2023-05-10
DATE OF DISCHARGE: 2023-05-16 (To Home Hospice)

PRINCIPAL DIAGNOSIS: Malignant Bowel Obstruction secondary to Peritoneal Carcinomatosis from Metastatic Lung Adenocarcinoma.

SECONDARY DIAGNOSES:

Stage IV Lung Adenocarcinoma, Wild-Type, PD-L1 Negative (Progression after 1st line chemo-IO and 2nd line chemo).

- Metastatic Disease: Bilateral Adrenal glands, Peritoneum, Liver (new since last scans).
- Cancer Cachexia, Severe Malnutrition.
- Nausea and Vomiting, intractable prior to intervention.
- Abdominal Pain.
- Hypokalemia (resolved).
- Dehydration (resolved).
- Hypertension (chronic).
- History of Smoking (60 pack-years, quit 2018).

PERTINENT ONCOLOGIC HISTORY:

- Dx: Stage IV Lung Adeno (Aug 19, 2021). Presented with flank pain. CT showed suspicious LUL nodule and large bilateral adrenal masses (R 5cm, L 4cm). Brain MRI neg. Adrenal biopsy confirmed metastatic adeno, TTF-1+.
- Molecular/PD-L1: WT for common drivers. PD-L1 (22C3) TPS 0%, CPS <5, IC 0.
- 1L Rx: Carbo/Pem/Pembro (Sept 10, 2021 - June 2022). Stable disease initially, progression noted after ~9 months (enlarging adrenal mets).
- 2L Rx: Docetaxel 75mg/m2 q3wks (July 2022 - Nov 2022). Tolerated poorly (fatigue, neuropathy). Achieved stable disease for ~4 months. Discontinued due to cumulative toxicity / patient preference.
- Best Supportive Care: Dec 2022 - May 2023. Managed symptomatically outpatient. Declined further chemotherapy trials.

HOSPITAL COURSE:
Mr. Finch presented to the ED on 05/10/23 with 5 days of severe nausea, vomiting (bilious emesis), abdominal distension, inability to tolerate PO intake, and diffuse abdominal pain. Last bowel movement was 6 days prior. He appeared cachectic and uncomfortable.

- **Initial Workup:** Vitals stable initially, later developed tachycardia. Exam: Distended, tympanitic abdomen with diffuse tenderness, high-pitched bowel sounds initially, later hypoactive. Labs: WBC 12.5, Hgb 10.8, K 2.9, Cr 1.3 (baseline 1.0), Albumin 2.4. LFTs mildly elevated. Abdominal X-ray showed dilated loops of small bowel with air-

fluid levels, concerning for obstruction. CT Abdomen/Pelvis w/ contrast confirmed high-grade distal small bowel obstruction with a transition point in the mid-ileum. Also demonstrated diffuse peritoneal thickening/nodularity consistent with carcinomatosis (significantly progressed from last scan 4 months prior) and several new small hepatic lesions. Adrenal masses also larger.

- **Management:**
    - Made NPO, initiated aggressive IV fluids and electrolyte repletion (Potassium).
    - Nasogastric tube (NGT) placed to low intermittent suction, drained >1L bilious fluid initially, providing significant symptom relief. Output decreased over subsequent days.
    - Surgical Consultation: Evaluated patient, deemed poor surgical candidate for lysis of adhesions or bypass given diffuse carcinomatosis, poor nutritional status, and limited prognosis. Recommended continued non-operative management.
    - Pain/Nausea Control: Transitioned from PRN IV morphine/ondansetron to scheduled IV Hydromorphone and addition of Haloperidol IV for refractory nausea, with good effect.
    - Oncology/Palliative Care Consultations: Dr. Tanaka and Palliative team involved early. Confirmed patient's prior wishes against further aggressive interventions. Extensive goals of care discussions held with patient and family. Patient clearly expressed desire for comfort focus and discharge home if possible. Not a candidate for venting gastrostomy tube given prognosis and goals.
    - Transition Planning: As patient's nausea/pain became controlled on IV meds and NGT output minimalized (tolerated clamping), plan made for transition to home hospice. Equivalent subcutaneous/oral medications calculated (transition to SC hydromorphone via CADD pump, oral/transdermal anti-emetics). Home hospice agency arranged, DME (hospital bed, etc.) ordered. Family educated on medication administration and symptom management.

DISCHARGE CONDITION:
Stable for discharge to home hospice. NGT removed prior to discharge. Tolerating sips of clear liquids without nausea. Pain controlled on regimen below. Abdomen soft, non-distended off suction. Patient alert, oriented, understands transition to hospice. Wife prepared for caregiver role with hospice support.

DISCHARGE PLAN & MEDICATIONS (Hospice to manage):

- **Disposition:** Discharge home with 24/7 Home Hospice services.
- **Code Status:** DNR/DNI Confirmed.
- **Diet:** Advance diet slowly as tolerated for comfort, low residue liquids/soft foods initially.
- **Medications via Hospice:**
    - Hydromorphone SC infusion via CADD pump (dose based on last 24hr IV requirement, approx. 0.5 mg/hr basal + PRN boluses).
    - Haloperidol 1-2 mg PO/SL q6h scheduled for nausea.
    - Prochlorperazine 25 mg PR suppository q12h PRN nausea.
    - Scopolamine Patch 1.5 mg q72h for secretions/nausea.
    - Lorazepam 0.5-1 mg SL q4h PRN anxiety/agitation.
    - Comfort bowel regimen (Bisacodyl supp PRN, etc.).

- Discontinue most prior chronic meds (HTN meds, statin, diabetic meds - per hospice protocol/assessment).

FOLLOW-UP: Patient died on 2023-05-18

_____ M.D./D.O.
Anya Sharma, MD (Electronically Signed)