Metropolitan General Hospital - Discharge Summary

Patient Name: Gallagher, Frank Charles **MRN:** SYN073 **Date of Birth:** 02/23/1952

Date of Admission: July 29, 2023
Date of Discharge (Deceased): August 2, 2023 @ 14:50
Admitting Service: Hospital Medicine (Dr. Ramirez)
Consulting Services: Oncology (Dr. Reed), Palliative Care (Dr. Lee)

Admitting Diagnoses:
#1 Acute Hypoxic Respiratory Failure
#2 Altered Mental Status
#3 Severe Cancer-Related Pain
#4 Stage IV Lung Adenocarcinoma

Discharge Diagnoses (Final):
#1 Acute Hypoxic Respiratory Failure (Secondary to progressive pulmonary metastases / possible PE / aspiration) - Primary Cause of Death
#2 Progressive Neurological Decline / Delirium (Secondary to progressive CNS metastases / metabolic encephalopathy) - Contributing Cause of Death
#3 End-Stage Metastatic Lung Adenocarcinoma (KRAS G12C positive, refractory to multiple lines of therapy) - Underlying Cause of Death
#4 Status Post Stereotactic Radiosurgery for Brain Metastases
#5 Cancer Cachexia
#6 Malignant Pain Syndrome

Reason for Hospitalization: Patient was brought in by EMS called by family for acute worsening of shortness of breath, confusion, lethargy, and uncontrolled pain at home where he was receiving supportive care coordinated by outpatient palliative clinic.

Brief Pertinent History: Mr. Gallagher had Stage IV KRAS G12C Lung Adenocarcinoma diagnosed June 2021 (brain/lung mets). PDL1 1-49%. He received 1L Carbo/Pem/Pembro (July 2021 – June 2022) followed by 2L Sotorasib. Declined further systemic chemo trials May 2023 due to declining PS/preference. Managed supportively outpatient.

Hospital Course:
Patient arrived hypoxic (SpO2 low 80s on RA) and hypercapnic (initial VBG pCO2 65), tachypneic, tachycardic, and minimally responsive (GCS 9). He was placed on BiPAP emergently with improvement in oxygenation (SpO2 mid-90s) but remained lethargic with poor respiratory effort. Exam notable for cachexia, labored breathing, diffuse coarse rhonchi/crackles. Suspected diagnoses included progressive pulmonary tumor burden, pulmonary embolism (PE), pneumonia (community-acquired or aspiration), and/or CNS event causing respiratory depression/delirium.

- **Diagnostics:** Stat CT Head showed marked progression of multiple known intracranial metastases with increased edema and mass effect compared to prior MRI (~3 months ago). CT PE Angiogram was negative for acute PE but demonstrated extensive bilateral pulmonary metastatic disease significantly worse than prior

imaging, with findings suggestive of lymphangitic spread and possible superimposed aspiration pneumonia (bibasilar opacities). Labs revealed leukocytosis (WBC 17.2), mild hyponatremia (131), stable mild anemia (Hgb 10.5), elevated D-Dimer, and respiratory acidosis on VBG. Troponin negative. Blood cultures negative.

- **Management & Clinical Trajectory:**
    - **Goals of Care:** Given the rapid clinical decline and radiographic evidence of widespread, refractory cancer progression (both pulmonary and intracranial), immediate consultation with Oncology (Dr. Reed) and Palliative Care (Dr. Lee) occurred. Family (wife and daughter at bedside) confirmed patient's prior expressed wishes for comfort-focused care and avoidance of intubation or other life-sustaining measures. **DNR/DNI status confirmed.** Plan shifted to aggressive symptom management and transition towards end-of-life care.
    - **Respiratory Support:** BiPAP was continued initially for comfort and to facilitate family interactions but patient tolerated it poorly due to agitation/delirium. Transitioned to High-Flow Nasal Cannula (HFNC) at high FiO2, then eventually to Non-Rebreather Mask and finally nasal cannula only as goals focused purely on comfort and reducing burden of interfaces. Received Morphine IV pushes transitioning to continuous infusion for dyspnea/tachypnea management. Scopolamine patch applied for secretions.
    - **Neurologic Status:** Delirium persisted despite attempts at managing potential reversible causes (hypoxia improved slightly, electrolytes stable). High-dose IV Dexamethasone (10mg load then 4mg q6h) started empirically for cerebral edema failed to produce significant improvement. Haloperidol IV administered for agitation with limited effect. Patient became progressively less responsive over hospital days 2-4. No further seizures observed.
    - **Pain Control:** Patient unable to report pain but exhibited non-verbal cues (grimacing, restlessness initially). Transitioned from ineffective home PRN opioids to scheduled IV Hydromorphone continuous infusion, titrated based on presumed comfort and vital signs.
    - **Family Support:** Social work and chaplaincy involved extensively to support family through the rapid decline and end-of-life decision-making process. Family maintained constant vigil at bedside.
- **Death:** Patient developed worsening respiratory failure with periods of apnea and bradycardia on morning of 08/02. Continued to decline despite maximal comfort measures (opioid titration, oxygen). Pronounced dead at 14:50 on August 2, 2023. Family present at bedside.

Discharge Disposition: Deceased. Body released to funeral home.

_____ M.D.
John Carter, MD (Internal Medicine Resident PGY-2)
Dictated: 08/02/2023 / Signed: 08/03/2023
Attending Physician: Carlos Ramirez, MD (Hospital Medicine)