Palliative Care Service - Consult Note

PATIENT: Finchley, Gerald Thomas ("Gerry") **DOB:** 1954-09-22
MRN: SYN061
DATE OF CONSULT: April 10, 2024
CONSULTING SERVICE: Palliative Care (Dr. Jones)
REFERRING SERVICE: Medical Oncology (Dr. Tanaka)
REASON FOR CONSULTATION: Goals of Care Discussion and Complex Symptom Management in patient with refractory Stage IV Lung Cancer.

HISTORY OF PRESENT ILLNESS:
Mr. Finchley is a 69-year-old gentleman with a history of Stage IV Lung Adenocarcinoma diagnosed in November 2021. He presented initially with RUQ pain and weight loss. Staging revealed a LUL primary lesion, extensive bilobar liver metastases, and multiple osseous metastases (T-spine, ribs). Biopsy confirmed Adenocarcinoma, NGS was Wild-Type for common drivers, PD-L1 IHC (22C3) showed **TPS 15%, CPS 20, IC 1/+**.

- **First-Line Therapy (Dec 2021 - Feb 2023):** Received Carboplatin/Pemetrexed/Pembrolizumab q3 weeks x 4 cycles, followed by Pemetrexed/Pembrolizumab maintenance. Achieved initial stable disease with some tumor shrinkage. Progression noted in Feb 2023 with significant growth of liver metastases and worsening bone disease.
- **Second-Line Therapy (Mar 2023 - Aug 2023):** Started Docetaxel + Ramucirumab q3 weeks. Experienced considerable toxicity including Grade 3 fatigue, Grade 2 neuropathy, and recurrent Grade 3 neutropenia despite Pegfilgrastim support. Scans after ~5 months showed continued progression in liver and bone, with new peritoneal nodularity concerning for carcinomatosis. Therapy discontinued due to both progression and poor tolerance.
- **Third-Line Therapy Attempt (Sept 2023 - Oct 2023):** Brief trial of Gemcitabine monotherapy. Received 2 cycles, complicated by profound fatigue, thrombocytopenia requiring transfusion, and worsening performance status (ECOG 3). Scans showed further rapid progression. No further anti-cancer therapy pursued since October 2023.

Patient has been managed supportively by Oncology since then. Over the past 4-6 weeks, he has experienced accelerating decline with worsening fatigue (mostly bedbound), severe anorexia/cachexia (wt loss >50 lbs from baseline), increasing abdominal distension/discomfort, constipation alternating with diarrhea (likely overflow/laxative-related), and poorly controlled bone pain (primarily lower back/hips). His wife (primary caregiver) feels overwhelmed managing symptoms at home. Patient was admitted to hospital 3 days ago for symptom management and disposition planning. Oncology requests Palliative Care input to clarify goals and optimize comfort.

PAST MEDICAL HISTORY:

- Type 2 Diabetes Mellitus (on Metformin, Lantus insulin – poorly controlled recently)
- Hypertension (on Lisinopril)
- Hyperlipidemia (Atorvastatin stopped recently)

- Severe COPD (on Trelegy Ellipta, PRN albuterol)
- History of Smoking (70+ pack-years, quit 2020)

SOCIAL HISTORY: Retired postal worker. Lives with wife, Carol, in single-story home. Two adult children live out of state. Strong family support via phone. Expressed desire previously to remain home if possible.

MEDICATIONS (Inpatient, prior to Palliative adjustments):

- Oxycontin 30 mg PO BID
- Oxycodone 10 mg PO q4h PRN pain (using frequently)
- Metformin 1000 mg PO BID
- Lantus insulin 20 units SC QHS (variable glucose control)
- Lisinopril 10 mg PO Daily
- Trelegy Ellipta 1 puff daily
- Albuterol MDI PRN
- Senna-S 2 tabs PO BID
- Miralax 1 capful PO Daily
- Ondansetron 8 mg PO TID PRN nausea

REVIEW OF SYSTEMS (Per patient & wife):

- General: Profound fatigue (+), weakness (+), cachexia (+).
- Pain: Constant dull/achy low back/hip pain (6/10), sharp intermittent abdominal pain/cramping (7/10).
- GI: Anorexia (+), early satiety (+), intermittent nausea (+), constipation alternating with loose stools (+), abdominal bloating (+).
- Resp: Mild baseline dyspnea, slight increase recently. Occasional cough.
- Psych: Feels "worn out," discouraged. Denies suicidal ideation. Wife reports he seems more withdrawn.

OBJECTIVE:

- Vitals: T 37.1, BP 115/70, HR 95, RR 20, SpO2 94% on 2L NC (baseline home O2).
- Exam: Chronically ill appearing, cachectic male lying in bed. Appears fatigued but alert, oriented x3. Conjunctiva pale. Lungs: Diminished breath sounds, faint bibasilar crackles. Cor: RRR. Abd: Distended, tympanitic, diffusely tender (guarding mild). Bowel sounds hypoactive. Ext: Muscle wasting, trace edema. Skin: Thin, dry. ECOG PS 4.
- Labs: Hgb 9.5, WBC 8.0, Plt 130. Na 134, K 4.1, Cr 1.2 (baseline 0.9), BUN 35. Glucose 180-300 range. Albumin 2.2. LFTs: AST 80, ALT 75, Alk Phos 550, T Bili 1.5.

ASSESSMENT:
Mr. Finchley is a 69-year-old man in the terminal phase of metastatic lung cancer, refractory to multiple lines of chemotherapy. He has a heavy symptom burden including poorly controlled pain (nociceptive bone pain, likely visceral/neuropathic abdominal pain from tumor progression/carcinomatosis), severe cancer anorexia-cachexia syndrome (CACS), constipation/bowel dysfunction, fatigue, and likely adjusting emotionally to his prognosis.

His performance status is poor (ECOG 4), limiting further disease-directed therapy. Prognosis is poor, likely weeks. Goals of care need clarification to guide management.

RECOMMENDATIONS & PLAN:

1. **Goals of Care Discussion:** Held lengthy discussion with Mr. Finchley and his wife. Patient clearly states understanding that cancer is no longer treatable and focus should be entirely on comfort. Expresses strong desire to avoid further hospitalizations and to die peacefully, ideally at home *if* symptoms can be managed adequately. Wife agrees but voices concern about her ability to manage increasing needs. Confirmed **DNR/DNI** status.
2. **Pain Management:**
    - **Bone Pain:** Increase scheduled long-acting opioid. Recommend increasing Oxycontin to 40 mg PO BID. Continue Oxycodone 10 mg PO q2-3h PRN breakthrough.
    - **Abdominal Pain:** Likely multifactorial (visceral, distension, possibly neuropathic). Add scheduled adjuvant: Gabapentin 100 mg PO TID (start low due to renal adjustment/frailty), titrate cautiously for neuropathic/visceral component. Consider trial of Dexamethasone 2-4mg daily for inflammation/appetite/well-being, short-term trial. Add Hyoscyamine 0.125 mg SL q6h PRN cramping/spasm.
3. **Bowel Management:** Aggressive approach needed. STOP Senna-S (can worsen cramping). Continue Miralax 1 capful BID. Add scheduled Bisacodyl 10 mg PO QHS. Ensure Bisacodyl suppository available PRN if no BM >48h. Consider gentle tap water enema if impacted. Aim for soft BM q1-2 days.
4. **Nausea/Anorexia:** Optimize anti-emetics: Change Ondansetron to PRN only. Add scheduled Haloperidol 0.5 mg PO BID (good for opioid/metabolic causes). Continue Dexamethasone trial (see above). Encourage small amounts of preferred foods/fluids for pleasure, do not force intake. Artificial nutrition/hydration not indicated/desired.
5. **Fatigue/Weakness:** Acknowledge as primarily disease-related. Energy conservation. PT/OT consult for home safety eval / DME recommendations if planning home discharge.
6. **Dyspnea:** Continue O2 2L NC. Ensure Morphine IR liquid available (e.g., 5-10mg PO/SL q1h PRN dyspnea).
7. **Diabetes Management:** Simplify regimen for comfort/safety. Recommend STOP Metformin. Change Lantus to lower fixed dose (e.g., 10 units QHS) or discontinue entirely if PO intake minimal/risk of hypoglycemia outweighs benefit. Check fingersticks only if symptomatic. Target glucose <300-350, avoid symptomatic hypoglycemia.
8. **Psychosocial/Spiritual Support:** Social work consult to assess caregiver support needs, explore home hospice feasibility vs inpatient hospice options. Chaplain consult offered. Encourage frequent checks on emotional state.
9. **Disposition Planning:** Primary goal is discharge home with hospice if symptoms controlled & adequate caregiver support established. If not feasible, transition to inpatient hospice facility. Will reassess symptom control and home situation daily.

Thank you for this consultation. Will continue to follow with Oncology and Hospital Medicine team.

_____ M.D.
Marcus Jones, MD (Palliative Care Fellow) / Susan Lee, MD (Palliative Attending)

FOLLOW UP April 16, 2024: Patient's condition deteriorating.

FOLLOW UP April 23, 2024: Patient died today.