Metropolitan General Hospital - Discharge Summary (Deceased)

PATIENT: Rodriguez, Maria Isabel
MRN: SYN022 **DOB:** 1969-08-21
DATE OF ADMISSION: October 15, 2023
DATE OF DEATH: October 21, 2023 @ 04:15
ATTENDING PHYSICIAN: Dr. Carlos Ramirez (Hospital Medicine)
CONSULTING PHYSICIAN: Dr. Evelyn Reed (Medical Oncology), Palliative Care Service

ADMISSION DIAGNOSES: Seizures, Altered Mental Status, Respiratory Distress.

FINAL DIAGNOSES:

1. **Primary Cause of Death:** Respiratory Failure & Neurological Decline.
2. **Underlying Cause:** Progressive Metastatic Non-Small Cell Lung Cancer (Adenocarcinoma), KRAS G12V mutation positive, refractory to multiple lines of therapy.
3. **Contributing Conditions:**
    - Progressive Intracranial Metastases with Vasogenic Edema and Mass Effect.
    - Status Epilepticus (resolved with intervention).
    - Aspiration Pneumonia (suspected).
    - Malignant Cachexia.

PERTINENT HISTORY:
Ms. Rodriguez was a 54-year-old female diagnosed with Stage IV Lung Adenocarcinoma in March 2022 after presenting with new-onset seizures.

- **Diagnosis/Staging (Mar 2022):** Brain MRI revealed multiple enhancing lesions (largest R temporal 2.5cm with significant edema). Staging PET/CT showed a 1.8cm LUL primary, mediastinal nodes, and bilateral pulmonary nodules. Biopsy confirmed Adenocarcinoma. NGS identified **KRAS G12V mutation**. PD-L1 (22C3) **TPS 0%, CPS <5, IC 0**.
- **First-Line Therapy (Mar 2022 - Dec 2022):** Underwent SRS to brain metastases. Initiated **Carboplatin/Pemetrexed/Pembrolizumab** on March 30, 2022. Achieved initial stable disease systemically and post-SRS stability intracranially
- **First Progression (December 27, 2022):** Restaging scans showed progression of pulmonary nodules and slight growth of primary lesion. Brain MRI remained stable.
- **Second-Line Therapy (Jan 2023 - May 2023):** Given KRAS G12V mutation (for which no approved targeted therapy exists), she was started on **Docetaxel** 75 mg/m2 q3 weeks. Experienced significant toxicity (Grade 3 neutropenia, fatigue, neuropathy) and scans after 4 cycles showed further progression in lungs and new small liver metastases.
- **Third-Line Therapy Attempt (June 2023):** Brief trial of Gemcitabine monotherapy. Received only 1 cycle, poorly tolerated (severe fatigue, thrombocytopenia), scans showed rapid progression including growth of brain lesions despite prior SRS. Decision made with patient to transition to best supportive care focus due to declining PS (ECOG 3) and refractory disease. Enrolled in outpatient palliative care clinic.

FINAL HOSPITALIZATION COURSE (Oct 15 - Oct 21, 2023):
Patient brought to ED by family after experiencing multiple generalized tonic-clonic seizures at home over 12 hours, followed by persistent lethargy and increased respiratory distress. Last seizure occurred en route to hospital.

- **Presentation:** Post-ictal, poorly responsive. Tachypneic (RR 28-32), hypoxic (SpO2 88% on RA). Febrile T 38.5C. Exam notable for cachexia, coarse breath sounds/rhonchi bilaterally, poor air exchange.
- **Initial Management:** Placed on O2 via non-rebreather mask. Loaded with IV Levetiracetam and Lorazepam per seizure protocol, no further tonic-clonic activity observed. Broad-spectrum antibiotics (Ceftriaxone, Vancomycin) initiated for suspected aspiration pneumonia. IV fluids administered.
- **Workup:** CT Head showed marked progression of intracranial metastases with increased surrounding edema and midline shift compared to prior MRI (July 2023). Chest X-ray showed bilateral patchy opacities, worse at bases. Labs: WBC 15.8 (neutrophilia), Hgb 9.8, Plt 110k. Cr 1.1. LFTs elevated. Blood cultures drawn.
- **Goals of Care:** Oncology and Palliative Care consulted urgently. Reviewed prior discussions and confirmed with family (patient lacked capacity) that goals remained comfort-focused. Existing DNR/DNI order honored. No further anti-cancer therapy or aggressive interventions (e.g., intubation, ICU transfer) desired.
- **Clinical Decline:** Despite anti-epileptics and supportive care, patient remained poorly responsive with persistent respiratory distress requiring high levels of supplemental oxygen (HFNC attempted for comfort but poorly tolerated). Developed worsening hypoxia and signs of respiratory fatigue. Transitioned to comfort measures only (CMO) on hospital day 3, focusing on managing dyspnea (IV morphine drip), secretions (scopolamine), and ensuring patient dignity. Antibiotics discontinued. Anti-epileptics continued initially for seizure prevention then stopped as patient became comatose. Family remained at bedside.

CIRCUMSTANCES OF DEATH: Patient experienced progressive respiratory failure and neurological decline, becoming unresponsive. Respirations became shallow and agonal. She passed away peacefully on October 21, 2023 at 04:15.

DISPOSITION: Body released to funeral home per family arrangements. Bereavement support offered.

_____ M.D./D.O.
Carlos Ramirez, MD (Electronically Signed)