Hospital Consult Note (Oncology)

SERVICE: Medical Oncology Consultation
DATE: July 18, 2022
PATIENT: Jones, Michael Gregory **ID:** SYN165 **DOB:** Nov 27, 1954
(**CONSULTANT:** V. Wells, MD
REFERRING: A. Sharma, MD (Hospital Medicine)

REASON FOR CONSULT: Worsening dyspnea and rapid clinical decline in patient with Stage IV Lung Cancer, recently completed second-line chemotherapy. Evaluate for disease progression vs treatment complication vs intercurrent illness; assist with goals of care / disposition planning.

HPI: Mr. Jones is a 67 y/o M with Stage IV Lung Adeno (WT, PDL1 <1%) dx Apr 2021 (mets to bilateral adrenals). Received 1L Carbo/Pem/Pembro (Apr 19, 2021 – Jan 15 2022). Progressed in adrenals + new lung nodules. Started 2L Docetaxel Feb 2022. Completed 4 cycles (last dose mid-May 2022), complicated by Gr 2 neuropathy & fatigue. Restaging CT June 2022 showed stable disease. Decision made outpatient to hold further chemo temporarily for QOL recovery. Presented to ED 2 days ago (July 16) with 1 week of rapidly worsening DOE (now dyspneic at rest), productive cough (yellow sputum), subjective fevers, and profound fatigue/weakness (ECOG 3-4). Admitted by Dr. Sharma for workup of respiratory failure.

PMH: Severe COPD (on Trelegy + PRN Albuterol, baseline O2 2L NC nocturnally), HTN, Ex-smoker (50+ppy).

HOSPITAL COURSE (Brief Summary from Hosp Med Note):

- **Initial Findings:** Febrile T 38.6, Tachycardic 110, Tachypneic 28, Hypoxic SpO2 88% on RA (req 4-6L NC). Exam: Cachectic, appears ill, using accessory muscles. Diffuse coarse crackles/rhonchi bilaterally. Labs: WBC 16.5 (88% N), Hgb 10.0, Plt 145. Cr 1.2. Procalcitonin 1.5 ng/mL. COVID/Flu/RSV neg. CXR/CT Chest: Extensive bilateral ground-glass & consolidative opacities, superimposed on known metastatic nodules (which appear slightly larger vs June scan). Small bilateral pleural effusions. No PE.
- **Management:** Admitted for likely Community-Acquired Pneumonia (CAP) in immunocompromised host (recent chemo) with likely contribution from underlying cancer progression/COPD exacerbation. Started broad-spectrum IV Abx (Cefepime/Vancomycin initially, pending cultures), IV fluids, O2 support, systemic steroids (Solumedrol 40mg IV BID) for presumed COPD component/inflammation. Blood/sputum cultures pending.

ONCOLOGY ASSESSMENT: Reviewed recent imaging. Bilateral infiltrates/consolidation clearly represent acute process (pneumonia favored given fever/leukocytosis/procalcitonin) superimposed on baseline metastatic disease. However, underlying pulmonary metastatic nodules do appear subtly progressed compared to June 2022 scan. Given recent completion of Docetaxel with SD followed by rapid decline, high suspicion for underlying disease progression contributing significantly to current presentation and poor prognosis.

DISCUSSION W/ PATIENT/FAMILY (Wife present): Explained findings – likely severe pneumonia in context of advanced, progressing lung cancer. Even if pneumonia treated successfully, underlying cancer prognosis remains very poor (likely weeks to few months at best). Discussed risks/benefits of potentially resuming chemotherapy (likely intolerable/ineffective) vs focusing purely on comfort. Patient is currently frail (ECOG 3-4), fatigued, dyspneic. He verbalized understanding and expressed desire to **avoid further chemotherapy** and focus on **comfort and quality of time remaining.** Wife in agreement. **DNR/DNI status confirmed.**

RECOMMENDATIONS:

1. **No further anti-cancer therapy indicated.** Transition to comfort-focused care.
2. Continue treatment for presumed pneumonia as guided by Hospital Medicine/ID (if consulted), but with understanding that goals are palliative (symptom relief) rather than curative. Duration/intensity of antibiotics can be reassessed based on clinical response and overall goals.
3. **Aggressive Symptom Management:** Utilize opioids (e.g., morphine) PRN/scheduled for dyspnea & pain. Manage secretions. Treat anxiety. Ensure bowel regimen. Optimize COPD management (continue inhalers, steroids as indicated for exacerbation).
4. **Palliative Care Consult:** Formal consult recommended to assist with complex symptom management, GOC reinforcement, and discharge planning (likely to hospice).
5. **Disposition Planning:** Unlikely candidate for discharge home given current state. Discuss transition to inpatient hospice facility or potentially continued inpatient palliative care unit stay for end-of-life care once infection component stabilized/treatment completed.

Thank you for this consultation. Will remain available for further discussion.

NOTE: PATIENT DIED ON 28th OF SEPTEMER 2022