Patient: Green, Harold Francis **ID:** SYN091 **DOB:** Jan 2, 1952

Inpatient oncology consult note

Metropolitan general hospital - oncology consult service

Date of consultation: May 5, 2023

Consulting physician: Vivian Wells, MD (medical oncology)
Referring physician: Carlos Ramirez, MD (hospital medicine)
reason for consultation: worsening bone pain and consideration of further treatment options vs. Goals of care clarification in patient with progressive stage iv lung adenocarcinoma.

History of present illness:
mr. Green is a 71-year-old male with a history of stage iv lung adenocarcinoma diagnosed in november 2021. He initially presented with persistent flank pain and fatigue. Staging revealed a small rll primary, bilateral adrenal metastases, and extensive osseous metastases (spine, pelvis, ribs). Brain mri was negative. Biopsy of an adrenal lesion confirmed metastatic adenocarcinoma. Molecular testing was **wild-type** for common drivers. Pd-l1 ihc (22c3) showed **tps 10%, cps 15, ic score 1/+**.

- **1L therapy (dec 2021 – mar 2023):**
  - started **carboplatin/pemetrexed/pembrolizumab** on dec 9, 2021. Completed 4 induction cycles followed by pemetrexed/pembrolizumab maintenance. Achieved stable disease with improvement in adrenal lesions and sclerosis of some bone lesions. Tolerated reasonably well (gr 1 fatigue, gr 1 anemia). Maintained good ps (ecog 1) for over a year. Progression noted on surveillance ct scans march 10, 2023 with enlargement of adrenal mets and development of new lytic components/new lesions in bone (esp. Lumbar spine, right hip).
- **2L therapy (mar 2023 - present - interrupted)**
  - started **docetaxel 75 mg/m2 iv q3 weeks** on march 28, 2023. Received only **one cycle**. Experienced significant toxicity including grade 3 fatigue, grade 2 mucositis, and profound worsening of bone pain, particularly in his lower back and right hip, requiring opioid dose escalation (now on oxycontin 20mg bid + oxycodone 10mg q4h prn, using frequently). Presented to ed 3 days ago due to intractable pain and inability to ambulate. Admitted by hospital medicine for pain management.

Hospital medicine requests oncology input regarding suitability for further docetaxel (cycle 2 due approx. Now), alternative treatment options, potential role for palliative radiation, and overall goals of care. Patient currently reports severe pain (8/10) despite opioids, significant fatigue, anorexia, and feels "very discouraged." wife at bedside expresses concern about his rapid decline since starting docetaxel.

Past medical history: hypertension, bph, osteoarthritis, appendectomy. Smoker (40 pack-years, quit 5 yrs ago).

Current medications (inpatient): oxycontin 20mg po bid, oxycodone 10mg po q4h prn, lisinopril 10mg daily, tamsulosin 0.4mg daily, senna-s, miralax, ondansetron prn.

Review of systems: dominated by severe pain (low back, r hip), severe fatigue, weakness, anorexia, constipation. Denies fever, cough, sob at rest.

Objective:

- Vitals: stable. T 37.2, bp 130/75, hr 88, spo2 96% ra.
- Exam: chronically ill, fatigued man in mild distress due to pain. Lying in bed. Cachectic appearance. Lungs clear. Cor rrr. Abd soft. Marked tenderness over lumbar spine and r greater trochanter. Decreased rom r hip due to pain. Strength 4/5 le globally. Sensation intact. Ecog performance status currently 3-4.
- Labs: wbc 7.5, hgb 10.2, plt 180. Cr 1.1 (stable). Lfts wnl. Alk phos 480 (up from 350 pre-docetaxel). Calcium 9.5.
- Imaging (repeat ct spine/pelvis from this admission): confirms extensive lytic/blastic metastatic disease, particularly l2-l5 and r proximal femur/acetabulum, possibly slightly worse than march 2023 scan. No impending fracture identified but large burden.

Assessment:

1. **Stage iv lung adenocarcinoma (wt, pd-l1 low):** progressed through first-line chemo-io after 15 months. Currently experiencing significant disease progression (bone mets) and severe symptoms (pain, fatigue), potentially exacerbated by toxicity from first cycle of second-line docetaxel. Performance status has declined significantly (ecog 3-4).
2. **Severe malignant bone pain:** poorly controlled on current opioid regimen, significantly impacting function and quality of life. Likely primary driver of admission.
3. **Poor tolerance to docetaxel:** significant toxicity after only one cycle, concurrent with worsening symptoms, making continuation challenging and potentially detrimental.

Recommendations / plan:

1. **Goals of care:** held detailed discussion with mr. Green and his wife regarding current situation, poor prognosis (likely months), limited benefit vs significant burden of further chemotherapy. Patient states primary goal is now **comfort** and maximizing quality of time remaining. Expresses desire to **avoid further chemotherapy** given recent experience and declining state. Agrees focus should be on symptom control. Dnr/dni status discussed and confirmed.
2. **Discontinue docetaxel:** will not proceed with cycle 2. No other standard chemotherapy options likely to offer significant benefit with acceptable qol in this setting.
3. **Pain management optimization:**

    - **Palliative radiation oncology consultation:** stat consult requested today for evaluation for palliative rt to lumbosacral spine and potentially right hip/pelvis for pain control. This is the most likely intervention to improve pain significantly.
    - **Pharmacologic:** continue scheduled long-acting opioid (oxycontin), potentially increase dose after rt if needed. Optimize breakthrough dosing frequency/route (consider iv/sc transition if po difficult or pain severe). Add **dexamethasone 4 mg po bid** - may help with inflammation from bone mets, potentially improve pain, appetite, fatigue (discuss short-term trial, risks/benefits). Continue aggressive bowel regimen. Consider adjuvant like gabapentin if neuropathic component suspected, but prioritize rt first.
4. **Symptom management:** continue supportive care for fatigue (energy conservation), anorexia (focus on preferred foods, consider megestrol acetate trial if desired by patient after steroid trial), nausea (continue prns), constipation.
5. **Discharge planning:** once pain better controlled (post-rt assessment) and symptoms stabilized, goal is discharge to appropriate setting. Given current ecog 3-4 and symptom burden:
    - **Home hospice:** preferred option if feasible with adequate caregiver support and symptom control. Requires assessment by hospice agency.
    - **Inpatient hospice facility:** alternative if home care not feasible or symptom management remains complex.
    - Social work / case management consult essential to facilitate disposition planning.
6. **Follow-up:** will follow patient daily with hospital medicine and palliative care teams while inpatient to manage symptoms and coordinate disposition.

Thank you for this important consultation.

_____ m.d.
Vivian wells, md (medical oncology - electronically signed)

(cc: dr. Ramirez, palliative care service)