Memorial Cancer Pavilion - Oncology Service
End of Life Care Summary & Attestation of Death

Patient Name: White, Walter Hartwell
MRN: SYN043 **DOB:** 05/15/1948 (Age 74 at death)
Date of Initial Diagnosis: November 6, 2019
Date of Death: November 10, 2022 @ 11:50 PM

Summary of Oncologic Illness & Terminal Course:
Mr. White was a 74-year-old gentleman with a history of Stage IV Non-Small Cell Lung Cancer (Adenocarcinoma, WT, PD-L1 High) diagnosed three years prior to his death. His journey was marked by an initial excellent response to immunotherapy followed by eventual resistance and progression through standard second and third-line chemotherapy regimens, ultimately leading to multi-organ failure and death.

- **Diagnosis & Initial Treatment (Nov 2019):** Presented with chronic cough and weight loss. Staging PET/CT revealed a large LUL primary mass, extensive mediastinal adenopathy, multiple bilateral pulmonary nodules, numerous liver metastases, and widespread osseous metastases (spine, ribs, pelvis). Brain MRI negative. Biopsy confirmed Adenocarcinoma. NGS was Wild-Type for common drivers. PD-L1 IHC (22C3) was **TPS 90%, CPS 95, IC Score 3/+**. Given high PD-L1, started first-line **Pembrolizumab 200 mg IV q3 weeks on Nov 28, 2019**.
- **First-Line Response & Progression (Nov 2019 - Mar 2021):** Experienced a dramatic partial response with near resolution of liver metastases, significant shrinkage of lung lesions/nodes, and stabilization/sclerosis of bone lesions. Maintained ECOG PS 0-1 and good quality of life for approx. **16 months**. Progression noted on surveillance CT in March 2021 with slow regrowth of liver lesions and several bone lesions. Pembrolizumab discontinued.
- **Second-Line Therapy (Apr 2021 - Oct 2021):** Initiated **Docetaxel 75 mg/m2 + Ramucirumab 10 mg/kg IV q3 weeks**. Tolerated initial cycles with expected fatigue, alopecia, Grade 1 neuropathy. Required Pegfilgrastim support. Achieved stable disease for approx. 6 months. Progression noted in October 2021 with further growth of liver mets and new pulmonary nodules. Therapy discontinued due to progression and increasing fatigue/neuropathy impacting QOL.
- **Third-Line Therapy (Nov 2021 - Mar 2022):** After discussion, opted for **Gemcitabine 1000 mg/m2 IV D1, 8 q3wks**. Experienced significant myelosuppression (dose reductions required) and debilitating fatigue. Scans after 4 months showed continued slow progression in liver and lungs. Therapy discontinued due to lack of benefit and toxicity. Performance status declined to ECOG 2-3.
- **Best Supportive Care / Palliative Focus (Apr 2022 - Nov 2022):** Extensive goals of care discussion. Patient declined further chemotherapy trials. Focus shifted to symptom management under joint care of Oncology and Palliative Medicine clinic. Managed increasing bone pain (required scheduled long-acting opioids – Oxycontin titrated up to 40mg BID + breakthrough Dilaudid), worsening fatigue, anorexia, and cachexia (lost >40 lbs from baseline). Received palliative radiation to painful L hip lesion (July 2022) with partial relief. Developed progressive hepatic dysfunction (rising LFTs, mild jaundice) and ascites requiring intermittent paracentesis starting Sept 2022.

Final Admission & Death (Nov 8 - Nov 10, 2022):
Admitted to inpatient oncology service from palliative clinic due to intractable nausea/vomiting, severe abdominal pain/distension (worsening ascites), increasing jaundice, and delirium. Found to have worsening hepatic failure (Tbili 8.5, AST/ALT >300, INR 1.8), worsening renal function (Cr 2.1), and likely hepatic encephalopathy contributing to delirium. Goals of care reaffirmed as comfort-focused (DNR/DNI). Aggressive symptom management initiated with anti-emetics (Haloperidol), opioids (transitioned to IV Dilaudid PCA), treatment for encephalopathy (Lactulose – limited effect). Paracentesis performed (3L removed) provided transient abdominal comfort. Despite maximal supportive measures, patient continued to decline rapidly with worsening delirium, deepening jaundice, oliguria progressing to anuria, and signs of multi-organ failure. Family remained at bedside. Patient became unresponsive on Nov 10th. Developed respiratory distress managed with opioids. Passed away peacefully later that evening.

Attestation: I, Vivian Wells MD, was the attending physician overseeing Mr. White's oncologic care. I concur with the summary provided and confirm the patient's death occurred on November 10, 2022, due to complications of metastatic lung cancer.

_____ M.D.
Vivian Wells, MD (Electronically Signed)
Medical Oncology