Patient: Elena Moretti (DOB 1969-01-19)

Medical Record Number: 527391

Date of Admission: 2025-03-18

Date of Discharge: 2025-03-23

Admitting Physician: Dr. L. Zhang (Medical Oncology)

Consulting Physicians: Dr. M. Patel (Gastroenterology), Dr. S. Kim (Nephrology)

**Discharge Diagnosis: HER2-/CLDN18.2+ Metastatic Gastric Adenocarcinoma with Clostridium difficile infection**

**1. Detailed Oncological Diagnosis:**

Primary Diagnosis: Gastric Adenocarcinoma, intestinal type, CLDN18.2 positive (3+ expression in >75% of tumor cells), HER2 negative.

Date of Initial Diagnosis: December 12, 2024 (confirmed by endoscopic biopsy).

Staging:

* Initial TNM (8th AJCC): cT3N2M1, Stage IV
* Metastatic sites: Multiple hepatic lesions (segments II, IV, VI, VII, largest 3.2 cm), peritoneal implants

Histology: Moderately to poorly differentiated intestinal-type adenocarcinoma (Lauren classification). Re-biopsy (January 2025) confirmed high CLDN18.2 expression (3+ immunohistochemistry in >75% of tumor cells) and HER2 negativity (0 by IHC).

Molecular/Genomic:

* CLDN18.2: Highly positive (3+ in >75% of cells by IHC)
* HER2: Negative (0 by IHC, FISH not performed)
* PD-L1 CPS: 5 (low positive)
* Microsatellite Status: MSS (stable)
* NGS Panel: KRAS wild-type, PIK3CA wild-type, FGFR2 amplification present, TP53 mutation present (c.817C>T; p.Arg273Cys)
* DPD testing: Gene activity score 2

**2. Current Treatment:**

C. difficile infection

* Vancomycin PO started on 2025-03-21
* IV fluid replenishment
* Electrolyte substitution

**3. History of Oncological Treatment:**

Surgical: None (unresectable at diagnosis)

Systemic Therapy:

Regimen: FOLFOX + Zolbetuximab (SPOTLIGHT trial-based regimen)

Zolbetuximab 800 mg/m² IV Day 1 (600 mg/m² from cycle 2 onwards)

Oxaliplatin 85 mg/m² IV Day 1

Leucovorin 400 mg/m² IV Day 1

5-Fluorouracil 400 mg/m² IV bolus Day 1, followed by 2400 mg/m² continuous IV infusion over 46 hours

* Cycle 1 FOLFOX + Zolbetuximab (January 31, 2025): Complicated by Grade 2 nausea/vomiting and Grade 1 peripheral neuropathy. Managed with enhanced antiemetics.
* Cycle 2 FOLFOX + Zolbetuximab (February 21, 2025): Complicated by Grade 2 nausea, Grade 1 diarrhea, and ongoing Grade 1 neuropathy. Infusion reaction to zolbetuximab (Grade 1) manifested as low-grade fever and chills, managed with additional premedications.
* Current Cycle: Cycle 3 Day 1 (administered March 16, 2025, two days prior to admission)

Imaging:

* Initial CT Chest/Abdomen/Pelvis (December 2024): 5.6 cm primary lesion involving gastric antrum and pylorus with perigastric lymphadenopathy. Multiple hypodense hepatic lesions consistent with metastases. Small volume peritoneal implants in right lower quadrant.
* PET/CT (December 2024): FDG-avid primary gastric lesion (SUV 8.5), perigastric and celiac nodes (SUV 5.2-6.8), and hepatic lesions (SUV 4.8-7.2).
* Surveillance CT (March 10, 2025): Stable disease by RECIST 1.1 criteria after 2 cycles of FOLFOX + zolbetuximab. Primary gastric lesion 5.3 cm (previously 5.6 cm), sum of target hepatic lesions 6.8 cm (previously 7.1 cm).

**4. Comorbidities:**

* Hypertension (diagnosed 2018, well-controlled)
* Type 2 Diabetes Mellitus (diagnosed 2019, moderately controlled, HbA1c 7.2% pre-admission)
* Hypothyroidism (diagnosed 2015, well-controlled on levothyroxine)
* Mild COPD (former smoker, 25 pack-years, quit 2019)
* Osteoarthritis (bilateral knees)

**Physical Exam at Admission:**

General: 56-year-old female appearing ill, fatigued, and mildly dehydrated. Vitals: BP 92/58 mmHg, HR 112 bpm, RR 22/min, Temp 37.7°C, SpO2 95% on room air. HEENT: Dry mucous membranes. No icterus. No lymphadenopathy.

Cardiovascular: Tachycardic, regular rhythm. No murmurs, rubs, or gallops. Respiratory: Bibasilar crackles, otherwise clear to auscultation.

Abdomen: Mild distension, diffuse tenderness most prominent in epigastrium and right upper quadrant. Hypoactive bowel sounds. No rebound or guarding. Implanted port site clean, intact.

Extremities: Trace bilateral lower extremity edema. No calf tenderness.

Neurological: Alert and oriented x3. Cranial nerves intact. Motor strength 4+/5 bilaterally due to fatigue. Sensation intact. Mild (Grade 1) oxaliplatin-related peripheral neuropathy in fingertips and toes.

Skin: Mild pallor. No rash. Acral erythema Grade 1.

**Epicrisis (Hospital Course Summary):**

Ms. Moretti is a 56-year-old female with CLDN18.2-positive metastatic gastric adenocarcinoma who was admitted after receiving Cycle 3 of FOLFOX + zolbetuximab with severe diarrhea.

Upon admission, the patient presented with hypotension (92/58 mmHg), tachycardia, nausea, severe diarrhea (7-8 loose, foul-smelling, watery stools in preceding 12 hours), and abdominal pain. Laboratory evaluation revealed acute kidney injury (creatinine 1.9 mg/dL from baseline 0.9 mg/dL), hypomagnesemia, hypophosphatemia, and elevated inflammatory markers (CRP 87 mg/L).

She was initially managed with aggressive IV fluid resuscitation (4L over first 24 hours), electrolyte repletion, antipyretics, and supportive care. The 5-FU pump was disconnected upon admission due to concern for severe toxicity. Stool samples were obtained for C. difficile toxin assay and were positive for C. difficile toxin B by PCR. Blood cultures were obtained (subsequently negative). Oral vancomycin 125 mg QID was initiated upon C. difficile confirmation, later increased to 250 mg QID due to severity of symptoms.

Nephrology was consulted for acute kidney injury, attributed to a combination of volume depletion from severe diarrhea and pre-renal factors. With aggressive hydration and electrolyte repletion, renal function improved (creatinine 1.2 mg/dL at discharge). Gastroenterology was consulted for management of C. difficile infection and recommended continuing oral vancomycin for a 14-day course.

The patient's hypotension resolved with fluid resuscitation, and she became afebrile on hospital day 3. Diarrhea frequency decreased to 2-3 loose stools per day by day 4. Nutritional support was provided with gradual advancement from clear liquids to a low-residue diet as diarrhea improved.

By discharge, the patient was hemodynamically stable, afebrile for >48 hours, with improved renal function, and significantly improved diarrhea. A multidisciplinary discussion was held, and the decision was made to continue the planned FOLFOX + zolbetuximab regimen after full recovery from the infection, with careful antimicrobial stewardship.

**Medication at Discharge:**

* Vancomycin 250 mg PO QID x 11 more days (14-day course total)
* Ondansetron 8 mg PO Q8H PRN nausea
* Acetaminophen 650 mg PO Q6H PRN pain/fever
* Pantoprazole 40 mg PO daily
* Amlodipine 5 mg PO daily (for hypertension)
* Metformin 500 mg PO BID (for diabetes)
* Levothyroxine 88 mcg PO daily (for hypothyroidism)
* Tiotropium 18 mcg inhalation daily (for COPD)
* Magnesium oxide 400 mg PO BID x 7 days (for hypomagnesemia)
* Potassium chloride 20 mEq PO daily x 5 days (for borderline hypokalemia)

**Further Procedure / Follow-up:**

Oncology Follow-up:

* Follow up with Dr. L. Zhang in 1 week (03/30/2025) for clinical assessment, toxicity evaluation, C. difficile status, and laboratory monitoring.
* Next treatment cycle (FOLFOX + zolbetuximab) tentatively scheduled for 04/07/2025, pending complete resolution of C. difficile infection and recovery from toxicities. Consider dose reduction.

Laboratory Monitoring:

* CBC, CMP, Mg, and Phosphate in 3-4 days (outpatient, 03/26-03/27), then again at oncology follow-up visit.

Imaging:

* Next CT scan for response assessment planned after 2 additional cycles of FOLFOX + zolbetuximab (approximately mid-May 2025).

Supportive Care:

* Nutrition consult arranged for outpatient follow-up within 2 weeks to address weight loss and dietary strategies during recovery from C. difficile and during chemotherapy.
* Referral to Palliative Care for symptom management and supportive care, scheduled for 04/03/2025.
* Infection control education provided regarding prevention of C. difficile transmission.

Patient Education:

* Instructed to immediately report recurrent fever, worsening diarrhea (>4 loose stools/day), inability to maintain oral hydration, or new symptoms.
* Educated about importance of oral hydration (goal 2-3 liters daily) and electrolyte replacement.
* Provided dietary guidelines for managing C. difficile-related gastrointestinal symptoms.
* Instructed on proper hand hygiene and infection control measures at home.

**9. Lab Values (Excerpt):**

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| --- | --- | --- | --- | --- |
| Parameter | Admission (3/18/2025) | Discharge (3/23/2025) | Units | Reference Range |
| WBC | 3.8 | 5.2 | x10^9/L | 4.0-11.0 |
| Absolute Neutrophil Count | 2.1 | 3.6 | x10^9/L | 2.0-7.0 |
| Hemoglobin | 10.2 | 9.8 | g/dL | 12.0-16.0 (F) |
| Platelets | 132 | 145 | x10^9/L | 150-400 |
| Creatinine | 1.9 | 1.2 | mg/dL | 0.6-1.1 (F) |
| BUN | 38 | 24 | mg/dL | 7-20 |
| Potassium | 3.6 | 3.8 | mEq/L | 3.5-5.0 |
| Magnesium | 1.4 | 1.8 | mg/dL | 1.7-2.2 |
| Phosphorus | 2.2 | 2.8 | mg/dL | 2.5-4.5 |
| AST | 42 | 35 | U/L | 10-35 |
| ALT | 38 | 32 | U/L | 10-35 |
| Total Bilirubin | 0.9 | 0.8 | mg/dL | 0.3-1.2 |
| Albumin | 3.2 | 3.3 | g/dL | 3.5-5.0 |
| C-Reactive Protein | 87 | 24 | mg/L | < 5 |
| eGFR | 32 | 52 | mL/min/1.73m² | >60 |
| Blood Cultures | No growth at 48 hours | - | - | No growth |
| C. difficile Toxin B PCR | Positive | - | - | Negative |

Electronically Signed By:

Dr. L. Zhang (Medical Oncology)

Date/Time: 2025-03-23 14:15

Dr. M. Patel (Gastroenterology)

Date/Time: 2025-03-23 13:30

Dr. S. Kim (Nephrology)

Date/Time: 2025-03-23 12:45