SAMPLE CANCER DIAGNOSIS LETTER — ONCOLOGY

1 Patient Information

1 PATIENT DETAILS

Name
Robert T. Kellerman

Date of Documentation
05/06/2026

DOB / Age / Sex
08/23/1959 | 66M

Provider
Dr. Vanessa L. Chen, MD — Medical Oncology

MRN
ONC-2026-1144

1 Purpose of Document

1 COMMUNICATION PURPOSE

This letter serves to communicate to the patient, his primary care physician, and interdisciplinary team the confirmed diagnosis of non-small cell lung cancer (NSCLC) in Mr. Robert T. Kellerman, established through tissue biopsy and comprehensive molecular profiling. This document is intended for clinical coordination, insurance authorization, and patient reference.

D Confirmed Diagnosis

2 DIAGNOSIS DETAILS

Cancer Type
Non-small cell lung carcinoma — adenocarcinoma subtype

Primary Site of Origin
Right upper lobe (RUL) of the lung, with ipsilateral mediastinal lymph node involvement

Histopathological Confirmation
CT-guided core needle biopsy of the right upper lobe mass (performed 04/18/2026): adenocarcinoma of the lung confirmed on hematoxylin and eosin staining. Immunohistochemistry: TTF-1 positive, p40 negative, napsin-A positive — consistent with primary lung adenocarcinoma.

Tumor Grade / Differentiation
Moderately differentiated (Grade 2). Lepidic growth pattern absent; acinar-predominant pattern identified.

Relevant Biomarkers / Receptor Status
EGFR mutation: Negative (exons 18–21 sequenced). ALK rearrangement: Negative (FISH). ROS1 rearrangement: Negative. KRAS G12C mutation: Positive (detected by NGS, FoundationOne CDx). PD-L1 expression: 65% tumor proportion score (TPS) by IHC (22C3 antibody). TMB: 12 mutations/megabase (intermediate). MET amplification: Not detected. BRAF V600E: Negative.

CF Clinical Findings

3 PRESENTING SYMPTOMS, IMAGING, PATHOLOGY

Mr. Kellerman presented to his primary care physician in March 2026 with a 3-month history of productive cough with occasional blood-streaking, a 14 lb unintentional weight loss, progressive dyspnea on exertion, and right shoulder pain. CT chest with contrast (04/05/2026) identified a 4.2 x 3.8 cm spiculated mass in the right upper lobe with ipsilateral mediastinal and hilar lymphadenopathy. PET-CT (04/12/2026) demonstrated FDG-avid right upper lobe mass (SUVmax 18.4) and FDG-avid right paratracheal (4R) and right hilar lymph nodes (SUVmax 9.2 and 7.8); no distant organ uptake. CT-guided core biopsy (04/18/2026) confirmed adenocarcinoma. Brain MRI (04/22/2026): No intracranial metastases identified. EBUS-TBNA of station 4R lymph nodes (04/28/2026) confirmed malignant cells in mediastinal sampling.

ST Staging (TNM)

4 TUMOR STAGING CLASSIFICATION

T — Tumor Size / Extent
T2b — Tumor >3 cm, ≤5 cm in greatest dimension (4.2 cm), involving the visceral pleura

N — Lymph Node Involvement
N2 — Ipsilateral mediastinal lymph node involvement (station 4R confirmed by EBUS)

M — Distant Metastasis
M0 — No distant metastases identified on PET-CT or brain MRI

Overall Stage Grouping
Stage IIIA (T2b N2 M0) per AJCC 8th Edition

CS Current Clinical Status

5 PATIENT'S CURRENT CONDITION

Symptom Burden
Right shoulder/chest wall pain (5/10), productive cough with blood-tinged sputum (daily), progressive dyspnea on exertion (MMRC grade 2), and fatigue (significant, limiting daily activities).

Functional Status (ECOG)
ECOG Performance Status: 1 — Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature.

Presence of Metastasis / Complications
No distant organ metastases identified on staging workup. No brain metastases on dedicated MRI. No bone lesions on PET-CT.

T Treatment Plan

6 RECOMMENDED MANAGEMENT

Following multidisciplinary tumor board review (05/04/2026), the recommended treatment approach for Stage IIIA, unresectable NSCLC with KRAS G12C mutation and PD-L1 TPS 65% is concurrent platinum-doublet chemoradiation followed by consolidation immunotherapy. Specific plan: 1. Concurrent chemotherapy — carboplatin AUC 2 weekly + paclitaxel 45 mg/m² weekly x6 cycles concurrent with definitive radiation. 2. Concurrent radiation therapy — 60 Gy in 30 fractions to gross tumor volume and involved nodal stations; radiation oncology consultation confirmed and planning underway. 3. Upon completion of chemoradiation (anticipated 6 weeks), consolidation durvalumab (Imfinzi) 10 mg/kg IV Q2 weeks x12 months, given PD-L1 TPS ≥1% and no disease progression post-CRT (per PACIFIC trial data). 4. KRAS G12C inhibitor (sotorasib or adagrasib) reserved for progressive/metastatic disease.

P Prognosis & Recommendations

7 PROGNOSIS

Stage IIIA NSCLC carries a 5-year overall survival rate of approximately 10–35% depending on response to multimodality therapy. The presence of KRAS G12C mutation may confer resistance to some targeted therapies but offers a targetable pathway upon progression. High PD-L1 TPS is a favorable predictive biomarker for consolidation immunotherapy benefit per PACIFIC trial data, which demonstrated improved PFS and OS in this setting.

8 RECOMMENDATIONS

1. Urgent referral to radiation oncology — simulation appointment scheduled 05/09/2026. 2. Pulmonary function testing (PFTs) to assess baseline prior to radiation. 3. Nutritional consultation given 14 lb weight loss. 4. Smoking cessation — patient is a former smoker (quit 4 years ago); no active tobacco use confirmed. 5. Infusion suite appointment for cycle 1 carboplatin/paclitaxel — 05/13/2026. 6. Palliative care consultation — symptom management during treatment.

F Follow-Up

9 MONITORING & TREATMENT TIMELINE

Follow-up Plan
Patient will be seen in oncology clinic weekly during concurrent chemoradiation for toxicity assessment. Post-CRT restaging CT chest/abdomen/pelvis at 4–6 weeks. Durvalumab initiation upon confirmed no disease progression. Follow-up brain MRI every 3 months during immunotherapy.

PROVIDER NAME	CREDENTIALS	DATE & TIME
Dr. Vanessa L. Chen, MD — Medical Oncology	MD — Medical Oncology	05/06/2026