

**1 Patient Information****1 PATIENT DETAILS**

<b>Name</b> Miriam L. Osei	<b>Date of Service</b> 05/06/2026
<b>DOB</b> 11/28/1956	<b>Provider</b> Dr. Fatima A. Ibrahim, MD — Palliative Care / Hospice Medicine
<b>Age / Sex</b> 69 / Female	<b>MRN</b> IP-2026-1148
<b>Visit Type</b> Inpatient Consult — Requested by Medical Oncology (Dr. Kim, MD)	<b>Primary Diagnosis</b> High-grade serous ovarian carcinoma, BRCA1 mutant, Stage IVB — platinum-resistant, progressive disease
<b>Care Setting</b> Inpatient — University Hospital, 6 North Oncology Unit, Dallas, TX	

**CC Chief Complaint****2 PRIMARY REASON FOR ENCOUNTER**

Palliative care consultation requested by medical oncology for: (1) Pain crisis — uncontrolled abdominal and pelvic pain rated 9/10 despite current oral opioid regimen; (2) Goals-of-care discussion — patient and family require structured goals-of-care conversation given progressive disease and declining functional status; (3) Advance care planning — patient has no documented advance directive; DNR/DNI status undiscussed; (4) Symptom burden — dyspnea, nausea, and malignant ascites management. Requesting guidance on overall goals of care and potential hospice transition planning.

**S Subjective****3 PATIENT-REPORTED SYMPTOMS, GOALS & INTERVAL HISTORY****3a SERIOUS ILLNESS HISTORY / INTERVAL STATUS**

Mrs. Osei was diagnosed with Stage IIIC high-grade serous ovarian carcinoma (HGSOC) in March 2023. She underwent optimal cytoreductive surgery (debulking) followed by adjuvant carboplatin/paclitaxel x6 cycles with complete clinical response. She relapsed in August 2024 (14 months post-completion), receiving second-line carboplatin/gemcitabine + bevacizumab — partial response. She progressed again in January 2026 — classified as platinum-resistant (PFI <6 months). She completed two cycles of liposomal doxorubicin (Doxil) as third-line therapy, discontinued in March 2026 due to progressive disease and mucositis intolerance. BRCA1 mutation confirmed (germline) — she received olaparib (PARP inhibitor) maintenance after first-line but progressed through it. She is now admitted for pain crisis and workup of new ascites (third presentation). CT abdomen/pelvis (05/04/2026): Progressive peritoneal carcinomatosis, new hepatic metastases (2 lesions), large-volume malignant ascites. Oncology team has advised that no standard further active therapy is appropriate at this time given performance status decline and platinum-resistant/multi-line-refractory disease.

### 3b SYMPTOM BURDEN

#### Pain

9/10 — diffuse abdominal and pelvic pain, constant with exacerbations, worst with movement and positioning. Currently on oxycodone ER 40 mg Q12h + oxycodone IR 10 mg Q4h PRN — using 5–6 PRN doses/day with inadequate relief.

#### Nausea / Vomiting

Nausea 6/10 — persistent; vomiting 2–3 episodes/day. Partially managed with ondansetron. Early satiety from ascites compression.

#### Fatigue / Weakness

Profound — spending 20–22 hours/day in bed. Unable to perform self-care activities independently.

#### Insomnia

Severe — pain and dyspnea preventing sleep. 2–3 hours/night of fragmented sleep.

#### Agitation

None currently — lucid and coherent.

#### Dyspnea

4/10 at rest; 7/10 with minimal exertion (walking to bathroom). SpO<sub>2</sub> 95% on 2L NC. Feels 'breathless and panicky' at night. No pleural effusion on CT.

#### Constipation

4 days without bowel movement — on senna/docusate but not effective. Concerned about impaction given opioid dose.

#### Anorexia

Complete loss of appetite x10 days — sipping liquids only. Refusing oral nutrition supplements.

#### Anxiety / Depression

Significant anxiety about dying — 'I'm scared of what's coming.' Tearful throughout encounter. No suicidal ideation.

#### Secretions / Other

No death rattle at this time. Bilateral pitting ankle edema 2+.

### 3c SYMPTOM SEVERITY & IMPACT

Mrs. Osei is bedbound 95% of the time. She cannot perform ADLs (bathing, dressing, transfers) without maximal assistance. She is unable to eat. Pain and dyspnea are the dominant symptoms impairing her quality of life. She rates her quality of life as 2/10 and states: 'I don't want to feel like this. I want to be comfortable and at peace.' Her daughter (present) confirms these have been her stated values throughout treatment. She is cognitively intact but visibly exhausted and distressed.

### 3d CURRENT TREATMENT RESPONSE

Oral oxycodone ER 40 mg Q12h + oxycodone IR 10 mg Q4h PRN: Inadequate — pain 9/10 at rest despite 5–6 breakthrough doses/day. IV hydromorphone PRN initiated by oncology last night (0.2 mg IV Q4h PRN) — provided 2–3 hours of partial relief. Ondansetron 8 mg PO/IV Q8h: Partially effective — nausea 6/10 persisting. Senna + docusate: Constipation persisting x4 days. Lorazepam 0.5 mg IV PRN: Used once overnight for dyspnea-related anxiety — helped briefly. Dexamethasone 4 mg IV BID: Started by oncology — modest appetite and nausea improvement expected; too early to assess.

### 3e PATIENT / FAMILY GOALS & PREFERENCES

Mrs. Osei was seen alone for 30 minutes prior to family involvement. She expressed: 'I've fought hard and I know I'm not getting better. I want to be comfortable — I don't want to die in pain or struggling to breathe. I want to go home if I can, or be somewhere peaceful.' She named her daughter, Christine Osei (47F), as her most trusted person and decision-maker. When asked about her values: 'Being with my family, being peaceful, and not suffering — that's what matters now.' She explicitly stated she does not want aggressive interventions: 'No more needles and machines if they can't cure me.' She has not completed any advance directive. She has not discussed code status with the oncology team previously.

### 3f PERTINENT NEGATIVES

Denies uncontrolled bleeding. Denies hemoptysis or hematemesis. Denies acute confusion or delirium (cognition intact, lucid). Denies suicidal ideation or desire to hasten death. Denies severe agitation. Denies stridor or imminent airway compromise. No fever today (98.4°F). No urinary retention.

## O Objective

### 4 MEASURABLE & OBSERVED FINDINGS

#### V VITAL SIGNS

##### Temperature

98.4°F

##### Heart Rate

98 bpm (mild tachycardia)

##### Oxygen Saturation

95% on 2L NC

##### Pain Score

9/10

##### Blood Pressure

104/62 mmHg (low — consistent with fluid shifts and disease burden)

##### Respiratory Rate

22 breaths/min (mildly elevated)

##### Weight

Not formally measured — estimated 10–12 lb weight loss in past 6 weeks per family

##### Performance Status

PPS 20% — mainly bed-based; limited self-care; ECOG 4

#### 4a PHYSICAL EXAMINATION

##### General Appearance

Cachectic, pale, visibly exhausted female. Resting with eyes closed, opens to voice. Jaundiced sclera bilaterally (new — hepatic involvement). Speaks in short sentences due to dyspnea.

##### Cardiovascular

Tachycardia 98 bpm, regular rhythm. Distant heart sounds. 2+ bilateral ankle edema. Peripheral pulses weak distally.

##### Abdomen

Massively distended — tense ascites. Dullness to percussion throughout, with shifting dullness. Diffuse tenderness on palpation, most severe at hypogastrium and right upper quadrant. Hepatomegaly 4 cm below right costal margin. No voluntary guarding.

##### Skin

Jaundice of sclera and mild skin yellowing. Sacral skin intact — Stage 1 erythema at coccyx. Bilateral ankle edema, 2+ pitting.

##### Psychosocial / Emotional

Tearful and frightened during assessment. Calmed with presence and verbal reassurance. Daughter Christine at bedside — visibly distressed, intermittently tearful, but composed.

##### Mental Status

Alert, oriented x3 (person, place, year — does not know exact date). Lucid for goal-directed conversation. No confusion or delirium. GCS 14 (E3V5M6).

##### Respiratory

Increased respiratory rate (22). Diminished breath sounds at right base — small right pleural effusion on exam. Mild intercostal retractions. No wheezing. Supplemental O<sub>2</sub> 2L NC.

##### Neurological

Cranial nerves grossly intact. Moves all extremities — strength globally 3/5 (deconditioning). No focal deficits.

##### Musculoskeletal

Profound muscle wasting of bilateral thighs and upper extremities. Temporalis and masseter wasting visible. Unable to stand without assistance.

## L Lab & Imaging Results

### 5 REVIEWED DATA

#### 5a LABORATORY STUDIES

Admission labs (05/05/2026): WBC 11.2 (mild leukocytosis — likely inflammatory, no infection identified), Hgb 8.6 (anemia — not transfusing per patient's goals), Plt 142. CMP: Na 128 (hyponatremia — SIADH vs. malignant), K 3.6, Cr 1.4 (mild AKI — pre-renal, limited intake), albumin 1.8 (severely low — malnutrition and hepatic involvement), total bilirubin 3.2 (elevated — hepatic metastases), AST 188, ALT 142, alk phos 342 (significantly elevated — biliary obstruction vs. hepatic mets). CA-125: 4,840 U/mL (markedly elevated — progressive disease marker). Lactate: 2.8 mmol/L (mildly elevated). Prognosis informed by: albumin 1.8, bilirubin 3.2, performance status decline — likely weeks to 1–3 months based on clinical picture.

#### 5b IMAGING STUDIES

CT abdomen/pelvis with contrast (05/04/2026): Progressive peritoneal carcinomatosis — diffuse peritoneal implants throughout abdomen and pelvis, largest omental implant 5.2 cm. Large-volume malignant ascites. New hepatic metastases: 2 lesions (right lobe, largest 3.4 cm). No bowel obstruction identified. No pleural effusion on CT (small effusion now clinically evident on exam since CT). Compared to CT 12/2025: Markedly progressive disease.

#### 5c OTHER CLINICAL DATA

Oncology note (Dr. Kim, 05/05/2026): 'No further active oncologic therapy appropriate — platinum-resistant, multi-line refractory disease, ECOG 4. Goals-of-care discussion pending palliative care consultation. Patient requires comfort-focused approach.' Prior advance directive: None on file. POLST/MOLST: Not completed. Code status: Full code (default — never discussed). Paracentesis performed 05/05/2026 (GI) — 4.8 L malignant ascites drained; cytology confirmed malignant cells. Temporary relief of dyspnea and discomfort post-procedure; expected to re-accumulate.

## A Assessment

### 6 PALLIATIVE CARE CLINICAL INTERPRETATION

Mrs. Miriam Osei is a 69-year-old woman with progressive, treatment-refractory Stage IVB BRCA1-mutant high-grade serous ovarian carcinoma presenting with a pain crisis, severely inadequate symptom control, and a prognosis of weeks to 1–3 months based on her clinical trajectory (PPS 20%, albumin 1.8, bilirubin 3.2, progressive hepatic and peritoneal disease). Her current symptom burden is severe: uncontrolled pain (9/10), significant dyspnea, refractory nausea, malignant ascites, constipation, and insomnia. Her stated goals — comfort, being with family, and avoiding suffering — are clearly comfort-focused and are in significant misalignment with her current full code status and active IV therapy. She is cognitively capable of decision-making and has articulated clear preferences. She understands her illness is not curable and is progressing. Her daughter Christine is her primary support and designated decision-maker. A structured family meeting is essential today to document goals of care, establish

code status consistent with her values, discuss hospice transition, and optimize comfort-focused symptom management. Prognosis has been communicated clearly and compassionately to the patient and her daughter.

## P Plan

### 7 PALLIATIVE MANAGEMENT

#### 7a SYMPTOM MANAGEMENT

Pain: Transition from oral opioids to IV hydromorphone continuous infusion (PCA): Initiate hydromorphone 0.4 mg/hr continuous rate + 0.2 mg bolus Q15 min PRN (4 boluses/hr maximum). Discontinue oral oxycodone ER (patient unable to swallow reliably). Titrate infusion by 25–50% Q4–6h if pain remains >4/10. Dyspnea: Low-dose IV hydromorphone benefits both pain and dyspnea. Add low-dose lorazepam 0.5–1 mg IV Q4h PRN for dyspnea-related anxiety/air hunger. Fan therapy at bedside. O<sub>2</sub> 2L NC maintained. If dyspnea worsens and patient comfortable with palliative sedation as option — discuss at next visit. Nausea: Change ondansetron to scheduled Q8h (not PRN). Add haloperidol 0.5 mg IV Q8h for nausea refractory to ondansetron — superior for malignant bowel-related nausea. Constipation: Methylnaltrexone (Relistor) 8 mg SC today — opioid-induced constipation refractory to laxatives; if no bowel movement in 24h, consider manual disimpaction assessment. Increase polyethylene glycol 17g QD. Anxiety/Insomnia: Lorazepam 0.5 mg IV Q6h scheduled for anxiety and insomnia — titrate to comfort. Spiritual distress: Chaplain consult requested today. Ascites: Re-discuss with patient/family regarding indwelling PleurX catheter for home paracentesis drainage — may improve comfort and facilitate hospice eligibility for repeat drainage. Skin: Coccyx pressure injury Stage 1 — wound care consult for preventive protocol; air mattress ordered.

#### 7b REFERRALS & CARE COORDINATION

Hospice evaluation: Referral to inpatient hospice or home hospice pending goals-of-care meeting outcome. Most likely trajectory: home hospice with husband and daughter as caregivers, or inpatient hospice facility if symptom burden cannot be managed at home. Social Work: Urgent referral — Ms. Keisha Brown, MSW: caregiver support for Christine, community resources, home hospice logistics, financial resources (insurance/Medicare hospice benefit). Chaplaincy: Chaplain Reverend David Ikenna — consult placed today; family identified as practicing Methodist. Wound Care: Stage 1 sacral pressure injury — consult placed. Ascites/PleurX: GI/interventional radiology referral for PleurX catheter placement consideration — discussed with patient, agreeable.

#### 7c PATIENT / FAMILY EDUCATION

Extensive illness understanding discussion provided to patient and Christine (45-minute family meeting today, see ACP section below). Explained: (1) The disease is no longer treatable and is progressing despite all available therapies; (2) The focus of care is shifting entirely to comfort and quality of life; (3) The hydromorphone PCA will be titrated to keep her comfortable — there is no ceiling on comfort medication in this setting; (4) Hospice services provide specialized comfort care at home or in a facility; (5) A POLST form will be completed today reflecting her wishes. Mrs. Osei and Christine expressed deep gratitude for the honest and compassionate communication. Christine stated: 'We just want her to be comfortable and to die with dignity.'

## ACP Advance Care Planning / Goals of Care

### 8 GOALS-OF-CARE DISCUSSION & DOCUMENTATION

#### 8a PATIENT UNDERSTANDING & DECISION-MAKING

##### Patient's Understanding of Illness / Prognosis

Mrs. Osei verbalized: 'I know I am dying. My cancer has kept coming back and the doctors have told me there are no more treatments.' She accurately described her prognosis as 'weeks to a couple of months' after the physician communicated this clearly and compassionately.

##### Healthcare Proxy / Decision-Maker

Christine Osei (daughter, age 47) — verbally designated as primary healthcare proxy today. DPAHC to be completed and notarized. Contact: 214-555-0178.

#### 8b ADVANCE DIRECTIVES & CODE STATUS

##### Advance Directives

No prior written advance directive. Patient verbally articulated comfort-focused wishes — POLST completed today and signed by patient and physician.

##### POLST / MOLST Status

POLST completed 05/06/2026 — Section A: DNR; Section B: Comfort-Focused Treatment; Section C: No artificial nutrition or hydration. Patient signed. Dr. Ibrahim signed. Copy in chart.

##### DNR / DNI Status

DNR/DNI — documented on POLST and order entered in chart by Dr. Ibrahim with oncology team co-signature requested.

##### Treatment Preferences & Limits of Care

Patient explicitly requests: no resuscitation, no mechanical ventilation, no ICU transfer, no artificial nutrition/hydration, no further chemotherapy or tumor-directed therapy. Comfort medications, oral intake as tolerated, and hospice care are requested and accepted.

8c FAMILY MEETING DETAILS

Family meeting conducted 05/06/2026 at 3:00 PM in patient's room. Attendees: Mrs. Osei (patient), Christine Osei (daughter), Dr. Fatima Ibrahim (Palliative Care), Dr. Lisa Kim (Medical Oncology), Keisha Brown MSW (Social Work). Duration: 45 minutes. Key discussion points: (1) Prognosis communication — weeks to 1-3 months; patient understood and accepted. (2) Goals of care — comfort and dignity; no further disease-directed therapy. (3) Code status — DNR/DNI agreed upon by patient and family. (4) Hospice transition — home hospice strongly preferred by patient; Christine willing to serve as primary caregiver with hospice nurse support. Home hospice evaluation to be arranged before discharge. (5) Planned discharge to home hospice within 2-3 days once pain is controlled on IV → subcutaneous opioid transition. Christine was given bereavement support resources and Hospice Foundation of America information. Mrs. Osei asked to hear her favorite hymn played softly on a portable speaker — chaplain facilitated this at end of meeting.

F Follow-Up

9 REASSESSMENT PLAN

Next Palliative Care Visit & Plan

Daily inpatient rounding while admitted. Reassess: pain control on PCA (titration as needed), dyspnea, nausea, constipation (methylalntrexone response), skin integrity. Home hospice agency referral to be completed by social work 05/07/2026. Transition from IV hydromorphone to subcutaneous hydromorphone for home hospice compatibility planned 05/08/2026. Discharge to home hospice target: 05/09/2026 if symptom stable. Family meeting Part 2 (discharge planning): 05/08/2026 with hospice agency representative, patient, Christine, social work.

TIME DOCUMENTATION & BILLING

Total Time

95 minutes

Counseling / Coordination Time

60 minutes

ACP Code

99497 — Advance care planning, first 30 min (face-to-face with patient and family, POLST completed)

Primary ICD-10

C56.9 — Malignant neoplasm of unspecified ovary

Advance Care Planning Time

45 minutes (family meeting, POLST completion, goals-of-care discussion)

E/M Level

99233 — Subsequent hospital care, high complexity

Basis for Billing

Time-based — 95 minutes total, 60+ minutes counseling/coordination; ACP billed separately per 99497

Secondary ICD-10

C78.6 — Secondary malignant neoplasm of retroperitoneum and peritoneum; C78.7 — Hepatic metastases; R52 — Pain, unspecified; J06.9 — Dyspnea; Z51.5 — Encounter for palliative care

PHYSICIAN / PROVIDER NAME

Fatima A. Ibrahim, MD

SPECIALTY: PALLIATIVE CARE

MD — Palliative Care / Hospice Medicine, FAAHPM

DATE

05/06/2026

TIME

4:45 PM