

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Delphine R. Achebe

DOB

11/29/1962

AGE / SEX

63 yrs / Female

MRN / PATIENT ID

ONC-2210884

DATE OF SERVICE

08/13/2026

PROVIDER

Samuel K. Brightwater, MD

CREDENTIALS

MD, FAAHPM

REFERRAL SOURCE

Medical oncology — urgent same-week referral

VISIT TYPE

Cancer Pain Management Follow-Up — opioid rotation and side effect management

CARE SETTING

Outpatient palliative care and pain clinic, co-located with oncology

PRIMARY ONCOLOGIST

Renata Salgado, MD — Breast Medical Oncology

PRIMARY CARE PROVIDER

H. Trevino, NP — Eastbank Internal Medicine

PALLIATIVE CARE PROVIDER

This service; embedded palliative RN, J. Moss, RN

CC CHIEF COMPLAINT

2 PRIMARY CANCER PAIN CONCERN

"The back pain is manageable now, but the medicine has taken me out of my own life. I sleep through the afternoon, I can't follow a conversation with my granddaughter, and I have not had a normal bowel movement in nine days."

S SUBJECTIVE

3 PATIENT-REPORTED CANCER PAIN HISTORY

3a ONCOLOGIC CONTEXT

Reason for evaluation

Opioid rotation for dose-limiting sedation, cognitive clouding and opioid-induced constipation in the setting of otherwise

adequate analgesia. Also for reassessment of incident bone pain, review of the 08/04/2026 restaging CT, and coordination of palliative radiotherapy planning.

Cancer history

Invasive ductal carcinoma of the left breast, ER+/PR+/HER2-, originally stage IIB (T2N1M0), diagnosed 03/2019. Left mastectomy with axillary dissection 05/2019, adjuvant chemotherapy, adjuvant radiotherapy to the chest wall, and 5 years of anastrozole. Metastatic recurrence 01/2026 with osseous disease at T9, the left iliac wing and the right femoral neck, plus limited hepatic metastases. Currently on ribociclib with fulvestrant, cycle 6, and denosumab every 4 weeks. Disease status on the 08/04/2026 CT: stable osseous disease, mild interval decrease in hepatic lesions.

3b PAIN PROFILE

Location and distribution

Two distinct pains. (1) Deep mid-thoracic pain centered at T9, band-like, radiating anteriorly around the left rib margin, corresponding to the vertebral metastasis. (2) Left lateral hip and buttock pain over the iliac lesion, worse with weight bearing. No pain at the femoral neck lesion. Additionally, bilateral stocking-distribution foot numbness and burning from prior taxane exposure.

Onset and course

Thoracic pain since 01/2026, progressive until controlled in 05/2026. Hip pain new since 06/2026 and slowly worsening. Both currently stable in intensity but the sedation burden has escalated over the past 3 weeks following the last dose increase.

Character and severity

Thoracic pain deep, boring, pressure-like; hip pain sharp and mechanical on loading; feet burning and electric. Current 3/10; best 2/10; worst 8/10 with transfers; average 3–4/10 over the past week. Breakthrough episodes reach 7–8/10.

Breakthrough pain

Three to five episodes daily, almost all incident and predictable — standing from a chair, walking more than 30 metres, and morning transfers. Onset within seconds of movement, duration 15–30 minutes. Immediate-release oxycodone 10 mg gives approximately 60% relief but takes 35–45 minutes, which is too slow for incident pain, and reliably causes 2–3 hours of somnolence.

Aggravating and alleviating factors

Aggravated by weight bearing, transfers, coughing and prolonged sitting. Relieved by lying supine, a lumbar roll, scheduled dosing, heat, and the walker. Denosumab has not changed the pain pattern.

3c SYMPTOMS, TREATMENT & CONTEXT

Associated symptoms

Prominent sedation and mental clouding, worst 2–3 hours after the morning long-acting dose. Nine days without a bowel movement despite senna. Intermittent nausea. Fatigue. Bilateral foot numbness with burning at night. Denies weakness, saddle anesthesia, and bladder or bowel incontinence. Mild lymphedema of the left arm, stable.

Functional impact

Uses a rolling walker outdoors, independent indoors. Requires assistance with lower-body dressing and bathing. Has stopped driving because of sedation. Sleeps 3–4 hours during the day, which disrupts night sleep. Has withdrawn from her weekly church choir and from caring for her 4-year-old granddaughter — the loss she names first and most often.

Current analgesic regimen and response

Extended-release morphine 60 mg PO q12h. Immediate-release oxycodone 10 mg PO q4h PRN, using 4–5 doses daily. Acetaminophen 1 g TID. Duloxetine 60 mg daily for CIPN, partial benefit. Dexamethasone 4 mg daily started 07/2026 for bone pain. Senna 2 tabs BID, inadequate. Ondansetron PRN. Analgesia is adequate; tolerability is not.

Opioid use and safety history

Total daily oral morphine equivalent approximately 195 mg (120 mg ER morphine plus 45–60 mg oxycodone as MME). No aberrant use behaviors. Refills consistently on schedule. PDMP reviewed today, concordant, single prescriber and single

pharmacy. Naloxone nasal spray dispensed 02/2026, in the home, husband trained. Medications stored in a locked box because of the grandchild in the home. Opioid agreement on file, signed 02/2026.

Cancer treatment-related pain

Taxane-induced peripheral neuropathy since 2019, grade 2, stable. Chronic post-mastectomy chest wall tightness, mild and non-limiting. Aromatase inhibitor arthralgia resolved after switching to fulvestrant. No radiation fibrosis pain, no mucositis.

Prior pain treatments

Palliative radiotherapy 8 Gy in a single fraction to T9 in 02/2026 with good partial response. Denosumab monthly since 02/2026. Physical therapy 6 sessions. No prior nerve block, vertebral augmentation, or neuraxial therapy. Acupuncture tried privately without benefit.

Relevant medical history

CKD stage 3a, eGFR 47 mL/min/1.73m² — relevant to morphine metabolite accumulation and very likely contributing to the sedation. Type 2 diabetes on metformin. Hypertension. No hepatic impairment. No sleep apnea. No respiratory disease. Platelets and ANC adequate. Not anticoagulated. No substance use history. No cognitive disorder prior to the current sedation.

Psychosocial / goals of care

Lives with her husband of 38 years; adult daughter and 4-year-old granddaughter live two streets away. Her stated priority, unchanged across three visits, is alertness sufficient to spend afternoons with her granddaughter, accepting a modestly higher average pain score in exchange. Advance directive completed 03/2026; husband is healthcare proxy. Full code at present, revisited today and unchanged. Not hospice-eligible and not seeking hospice; she is on active treatment with a response. Distress thermometer 6/10, primarily role loss rather than pain.

Recent testing / oncology updates

CT chest, abdomen and pelvis 08/04/2026: stable osseous metastases, no new lesions, interval decrease in two hepatic lesions. Labs 08/11/2026 reviewed. Oncology visit 08/05/2026 — continue current systemic therapy. No hospitalizations or emergency visits since 04/2026.

Pertinent negatives

Denies new or progressive weakness, gait deterioration beyond her baseline, saddle anesthesia, urinary retention or incontinence, fecal incontinence, fever, chills, vomiting, abdominal distension with obstipation and pain, chest pain, or shortness of breath. No respiratory depression. No acute abdomen. No cord compression symptoms.

ROS CANCER PAIN REVIEW OF SYSTEMS	
4 PERTINENT POSITIVES & NEGATIVES	
Cancer-related, bone, neuropathic, visceral or post-surgical pain	Positive — T9 and left iliac bone pain; CIPN of both feet.
Numbness, tingling, weakness, gait difficulty, falls, neurologic deficit	Positive for distal numbness. No weakness, no falls, no focal deficit.
Breakthrough pain, sleep disruption, fatigue, appetite or weight change	Positive — 3–5 incident episodes daily; fragmented sleep; weight stable.
Nausea, vomiting, constipation, obstruction symptoms, distension	Positive — 9 days without stool, intermittent nausea. No vomiting or distension.
Dyspnea, sedation, confusion, dizziness, respiratory symptoms	Positive — daytime sedation and mental clouding. No dyspnea, RR 16.
Aspirin, low-dose aspirin, low-dose aspirin, low-dose aspirin	Positive — Aspirin 81mg daily, low-dose aspirin 81mg daily

Anxiety, depression, distress, coping difficulty, quality of life	Positive — distress 6/10, role loss. Screens negative for major depression.
Medication side effects, opioid adverse effects, adherence barriers	Positive — sedation, constipation, nausea. Adherence excellent.
Fever, infection symptoms, bleeding/bruising, treatment complications	Negative throughout.

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE

98.0 °F

BLOOD PRESSURE

128/74 mmHg

HEART RATE

82 bpm

RESPIRATORY RATE

16 /min

OXYGEN SATURATION

97% RA

HEIGHT

5 ft 4 in

WEIGHT

143 lb (stable)

BMI

24.5

PAIN SCORE

3/10 rest · 8/10 with transfer

PERFORMANCE STATUS

ECOG 2 · Karnofsky 60

General appearance

Seated in a wheelchair on arrival, transfers with one-person assist. Awake but visibly drowsy; drifts off twice during history-taking and is easily roused. Not cachectic. No acute distress at rest. Grimaces on standing.

Cardiovascular / pulmonary

Regular rate and rhythm, no murmur. Peripheral pulses intact. Trace left upper extremity lymphedema, stable. Lungs clear bilaterally, unlabored breathing, no accessory muscle use, no oxygen requirement.

Abdomen

Soft, mildly distended, non-tender. Bowel sounds hypoactive. Firm stool palpable in the left lower quadrant. No ascites, no hepatomegaly, no mass. No rebound or guarding. Digital rectal examination deferred to the palliative RN visit, patient preference; no obstruction concern clinically.

Musculoskeletal

Focal tenderness on percussion over the T9 spinous process. Tenderness over the left iliac crest. Antalgic transfer pattern with left-sided offloading. No deformity. Right hip painless through full range — no clinical evidence of impending femoral neck fracture, though the lesion warrants ongoing surveillance.

Neurologic

Alert but sedation-limited attention; Richmond Agitation-Sedation Scale –1. Oriented to person, place and time; slow processing. Strength 5/5 in all four limbs including hip flexion and ankle dorsiflexion. Sensation reduced to light touch and vibration in a stocking distribution to mid-shin bilaterally. Reflexes 2+ and symmetric, no clonus, plantars downgoing. No sensory level, no saddle anesthesia. Gait with walker, steady but slow.

Skin / procedure sites

Left mastectomy scar well healed. Port-a-cath in the right chest, site clean and dry, no erythema or tenderness. No radiation dermatitis. No pressure injury. Skin turgor mildly reduced.

Psychiatric / behavioral

Mood described as “flat but not sad.” Affect congruent, tearful once when describing her granddaughter. Thought process linear though slowed. Insight and judgment intact. No suicidal ideation. Able to state her medication schedule accurately with prompting; husband manages the pill organizer.

PH CANCER PAIN CLASSIFICATION / PAIN PHENOTYPE

6 PAIN TYPE & CONTRIBUTORS

Predominant pain types

Mixed. (1) Nociceptive somatic bone metastasis pain at T9 and the left iliac wing, with a prominent *incident* component — movement-evoked, rapid in onset, short in duration. (2) Chemotherapy-induced peripheral neuropathic pain of both feet, grade 2, taxane-related, stable. No visceral pain, no tumor compression pain, no post-surgical pain syndrome of significance.

Contributors

Renal impairment driving accumulation of morphine-6-glucuronide is the principal mediator of the sedation and cognitive clouding. Opioid-induced constipation is compounding nausea and appetite loss. Fragmented sleep from daytime somnolence contributes to fatigue. Psychosocial contributor: loss of the caregiving role, which the patient weighs more heavily than pain intensity itself.

MS MEDICATION / OPIOID SAFETY ASSESSMENT

7 ANALGESIC SAFETY REVIEW

CURRENT OPIOID REGIMEN

ER morphine 60 mg q12h + IR oxycodone 10 mg q4h PRN

TOTAL DAILY ORAL MME

≈ 195 mg/day

SCHEDULED USE

120 mg MME — fully adherent

BREAKTHROUGH USE

4–5 doses/day, ≈ 75 mg MME

DURATION OF RELIEF

Scheduled 10–11 hrs; rescue 2–3 hrs, onset too slow

FUNCTIONAL IMPROVEMENT

Analgesia adequate; function limited by sedation

NALOXONE

Dispensed 02/2026, in the home, husband trained

SAFE STORAGE

Locked box — grandchild in the home

PDMP REVIEW

Reviewed 08/13/2026 — concordant, single prescriber

UDS / PILL COUNT

UDS 05/2026 consistent; agreement on file 02/2026

Side effects and dosing considerations

Dose-limiting sedation, cognitive clouding, opioid-induced constipation (9 days), and intermittent nausea. eGFR 47 mL/min/1.73m² makes morphine a poor choice — active glucuronide metabolites accumulate in renal impairment and account for the sedation out of proportion to dose. Dexamethasone 4 mg is contributing to insomnia and hyperglycemia.

No sedating co-medications otherwise; no benzodiazepines, no gabapentinoids. Duloxetine dose is appropriate for eGFR >30.

Rotation plan

Rotate from morphine to hydromorphone — the preferred opioid in CKD stage 3a — with a reduction for incomplete cross-tolerance, plus a rapid-onset agent matched to the incident pain pattern. Details in the Plan.

AT PAIN AND FUNCTIONAL ASSESSMENT TOOLS

8 SCORES, INTERPRETATION & COMPARISON

NUMERIC PAIN RATING SCALE

3/10 rest · 8/10 incident (unchanged from 07/16)

BPI — INTERFERENCE

7.6 / 10 (was 6.1 on 07/16 — worsening)

PEG SCALE

3 / 7 / 8 — mean 6.0

KARNOFSKY PERFORMANCE STATUS

60

DISTRESS THERMOMETER

6 / 10 — practical and family domains

FUNCTIONAL AND QUALITY-OF-LIFE GOALS

Alert enough for afternoons with her granddaughter and a return to Sunday choir; accepts average pain up to 4/10 to achieve this

BRIEF PAIN INVENTORY — SEVERITY

4.0 / 10

ESAS TOTAL

38 / 90; drowsiness 8, constipation 8, pain 3

ECOG PERFORMANCE STATUS

2 (was 1 in 05/2026)

CIPN — CTCAE GRADE

Grade 2, stable

OPIOID RISK

Low; no aberrancy, agreement current

L LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED OR ORDERED

Cancer imaging

CT chest / abdomen / pelvis 08/04/2026: stable sclerotic metastases at T9, left iliac wing and right femoral neck; no cortical breach at the femoral neck and no lucency to suggest impending fracture; two hepatic lesions decreased. MRI thoracic spine 02/2026: T9 metastasis with no epidural extension and no cord compression — no interval imaging indicated, as examination shows no myelopathic signs.

Laboratory studies

08/11/2026 — creatinine 1.28 mg/dL, eGFR 47; potassium 4.1; corrected calcium 9.4 mg/dL; albumin 3.4 g/dL; AST 28, ALT 24, bilirubin 0.7; ALP 168 (elevated, osseous); hemoglobin 10.6 g/dL; platelets 214 k; ANC 2.9 k; INR 1.0. Glucose 168 mg/dL and HbA1c 7.4% — steroid-influenced.

Treatment safety labs

Platelets, ANC and INR all within range for interventional procedures should vertebral augmentation or a nerve block become indicated.

Neurologic / spine testing

No new imaging. Serial examination is the surveillance strategy; the patient and husband have been given explicit cord-compression red flags.

Procedure reports and prior records reviewed

Radiation oncology record of the 02/2026 single-fraction 8 Gy to T9; denosumab administration log; oncology notes of 08/05/2026; physical therapy discharge summary 06/2026; pharmacy dispensing history.

A

ASSESSMENT

10 CANCER PAIN CLINICAL INTERPRETATION

- **Mixed cancer pain in metastatic ER+/HER2– breast carcinoma** — bone metastasis pain at T9 and the left iliac wing with a dominant incident component, plus stable grade 2 taxane-induced peripheral neuropathy. Analgesia at rest is adequate; the problem this visit is tolerability, not potency.
- **Opioid-induced neurotoxicity in the setting of CKD stage 3a.** Sedation and cognitive clouding are disproportionate to the MME and are best explained by accumulation of morphine-6-glucuronide at eGFR 47. This is a rotation indication, not a dose-reduction-alone indication.
- **Opioid-induced constipation, severe** — 9 days without stool on senna monotherapy, with secondary nausea and anorexia. No clinical or radiographic evidence of malignant bowel obstruction, but this requires resolution before the next escalation of any kind.
- **Incident pain phenotype mismatch.** Oral oxycodone with a 35–45 minute onset cannot cover a movement-evoked pain that peaks within seconds and resolves in 15–30 minutes. The current rescue regimen buys sedation without covering the episodes it is prescribed for.
- **No oncologic emergency.** No cord compression (normal strength, no sensory level, no sphincter dysfunction), no impending pathologic fracture at the femoral neck on the 08/04 CT, no hypercalcemia, no obstruction, no infection.
- **Goals-of-care alignment:** the patient explicitly trades a modest increase in average pain for restored alertness. The plan below is built to that preference, not to the lowest achievable pain score.
- **Contributing:** dexamethasone-related insomnia and hyperglycemia; distress from role loss rather than from pain intensity.

P

PLAN

11 CANCER PAIN MANAGEMENT BY PROBLEM

- **Opioid rotation (today):** discontinue extended-release morphine. Start hydromorphone ER 12 mg PO q24h, calculated from 195 mg MME with a 30% reduction for incomplete cross-tolerance and a further reduction for renal impairment. First dose tomorrow morning, 12 hours after the final morphine dose. Husband given a written cross-over schedule.
- **Breakthrough, matched to phenotype:** hydromorphone IR 2 mg PO q3h PRN for background breakthrough, plus fentanyl buccal 100 mcg PRN before *anticipated* incident pain — taken 10 minutes before transfers, walking, and getting up from a chair, maximum 4 doses daily. Pre-emptive dosing explained in detail; this is the single change most likely to restore her afternoons.

- **Constipation (priority today):** polyethylene glycol 17 g BID scheduled, senna increased to 2 tabs TID, and a one-time bisacodyl 10 mg suppository this evening. If no bowel movement within 48 hours, add methylnaltrexone 8 mg subcutaneously — prescription sent so it is in hand. Palliative RN to call in 48 hours. Escalate to imaging if pain, distension or vomiting develops.
- **Neuropathic pain:** continue duloxetine 60 mg daily — appropriate at eGFR 47. Do not add a gabapentinoid while sedation is the presenting problem; revisit in 4 weeks once alertness has recovered.
- **Bone-directed therapy:** continue denosumab every 4 weeks with calcium and vitamin D. Referral to radiation oncology for consideration of palliative radiotherapy to the left iliac lesion, which is now the dominant incident-pain generator — appointment requested within 10 days. Continue right femoral neck surveillance; orthopedic referral if pain develops there or the next CT shows cortical involvement.
- **Steroid taper:** reduce dexamethasone to 2 mg each morning for 7 days, then stop, contingent on the radiotherapy plan. This should improve sleep and glycemic control. Coordinate with oncology and notify primary care for diabetes monitoring.
- **Interventional:** not indicated today. If the iliac pain persists after radiotherapy, consider a CT-guided lateral branch or periosteal block, or cementoplasty. Platelets, ANC and INR are all adequate should this be pursued.
- **Non-pharmacologic and supportive:** re-refer to physical therapy for safe transfer technique and walker fitting; occupational therapy home assessment for bathroom equipment; heat therapy; sleep repositioning with a lumbar roll.
- **Coordination:** results and plan messaged to Dr. Salgado and to primary care today. Palliative RN telephone review at 48 hours and 7 days. Social work referral for caregiver support and transportation. Chaplaincy offered and accepted.
- **Goals of care:** revisited and documented — alertness prioritized over maximal analgesia; advance directive current; husband confirmed as proxy; full code unchanged. Hospice is not indicated during an active treatment response and was not raised as a current option.
- **Safety and escalation:** family counselled on naloxone use, on the specific red flags of new weakness, numbness in the groin or inner thighs, loss of bladder or bowel control, and on when to seek emergency care. Written instructions given; opioid disposal and locked storage reinforced.

F

FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up

Palliative RN telephone review in 48 hours for bowel response and rotation tolerance, and again at 7 days. Clinic follow-up in 10 days (08/24/2026) for pain reassessment, sedation and cognition re-evaluation, hydromorphone titration, review of the radiation oncology plan, and confirmation of the dexamethasone taper. Sooner if pain escalates, if the rotation is not tolerated, or if there is no bowel movement after methylnaltrexone. Immediate emergency evaluation for cord-compression symptoms, oversedation or respiratory depression.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

58 minutes

MEDICATION MANAGEMENT TIME

22 minutes

COUNSELING / GOALS-OF-CARE DISCUSSION

15 minutes

CARE COORDINATION TIME

11 minutes

RECORDS REVIEW TIME

6 minutes

PROCEDURE PLANNING TIME

Not applicable

PALLIATIVE CARE COORDINATION TIME

9 minutes — RN and social work handover

E/M LEVEL

99215 — established patient, high MDM (opioid rotation with drug therapy requiring intensive monitoring)

PROCEDURE CODE(S)

None this visit

MEDICATION MANAGEMENT / OPIOID MONITORING

PDMP reviewed 08/13/2026; opioid agreement current

CARE COORDINATION CODE(S)

99490 not billed — time captured within the E/M level

BASIS FOR BILLING

Medical decision making of high complexity; total time 58 minutes also documented

PRIMARY CANCER PAIN ICD-10

G89.3 — Neoplasm related pain (acute) (chronic)

UNDERLYING MALIGNANCY ICD-10

C50.912 — Malignant neoplasm of unspecified site of left female breast

SECONDARY ICD-10

C79.51 secondary malignant neoplasm of bone · C78.7 secondary malignant neoplasm of liver · G62.0 drug-induced polyneuropathy · K59.03 drug-induced constipation · N18.31 CKD stage 3a · Z79.891 long term opiate analgesic use

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Samuel K. Brightwater

CREDENTIALS

MD, FAAHPM

SPECIALTY

Cancer Pain / Palliative
Medicine

DATE

08/13/2026

TIME

11:22 AM