1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME	Rosalind K. Achterberg
DOB	07/19/1959
AGE / SEX	67 yrs / Female
MRN / PATIENT ID	GO-70884
DATE OF SERVICE	08/20/2026
PROVIDER	Priyanka S. Deshmukh, MD
CREDENTIALS	MD — Gynecologic Oncology
PRIMARY OB-GYN PROVIDER	Marguerite Oyelowo, MD (retired from her care)

VISIT TYPE
Chemotherapy follow-up — cycle 4 of neoadjuvant carboplatin/paclitaxel, interval debulking planning

CARE SETTING
Outpatient Gynecologic Oncology Clinic, comprehensive cancer center

PRIMARY CARE PROVIDER	REFERRING PROVIDER
Alan Weatherby, MD	Emergency department — initial presentation with ascites (03/2026)

ONCOLOGY CARE TEAM
Gyn onc: Dr. Deshmukh · Infusion RN: Kwame Antwi, RN · Palliative care: Dr. Lena Marchetti · Genetics: Sarah Kuhn, MS, CGC

INTERPRETER USED	CHAPERONE PRESENT
None required	Yes — Talia Brenner, MA, for the pelvic examination

CC CHIEF COMPLAINT

2 PRIMARY GYNECOLOGIC ONCOLOGY CONCERN

"The bloating and the tightness are gone — I can eat a full meal again and I got my waistband back. But my feet and fingers are numb and tingling all the time now, and I keep dropping things. I want to know whether the chemotherapy is working well enough to operate, and whether the numbness is going to be permanent."

S SUBJECTIVE

3 ONCOLOGIC SYMPTOMS, CANCER HISTORY & TREATMENT COURSE

3a REASON FOR EVALUATION & ONCOLOGIC HISTORY

Reason for Gynecologic Oncology Evaluation

Interval assessment after cycle 4 of neoadjuvant carboplatin and paclitaxel for stage IIIC high-grade serous ovarian carcinoma. Three purposes: (1) assess treatment response with CA-125 trend and restaging CT to determine candidacy for interval debulking surgery, (2) grade and manage progressive chemotherapy-induced peripheral neuropathy, and (3) review germline and somatic testing results that determine maintenance therapy.

Oncologic History

High-grade serous carcinoma of the ovary, FIGO stage IIIC, diagnosed 03/24/2026 at age 66. Presented to the emergency department with a 3-month history of abdominal distension, early satiety, and a 12 lb weight gain from ascites. CT showed a 9.2 cm right adnexal mass, an 4.1 cm left adnexal mass, omental caking, peritoneal implants, and moderate ascites without parenchymal liver or pulmonary metastasis. Paracentesis (4.2 L) with cytology showing malignant cells consistent with serous carcinoma; CA-125 at diagnosis **1,842 U/mL**. Image-guided omental core biopsy confirmed high-grade serous carcinoma: p53 aberrant, WT1 positive, PAX8 positive, Ki-67 70%. Deemed **not optimally resectable at presentation** by our team and by a second surgical opinion, based on omental caking to the splenic hilum, small-bowel mesenteric involvement, and her deconditioned state — hence neoadjuvant chemotherapy with planned interval debulking after 3–4 cycles. No prior gynecologic malignancy.

History of Present Illness

Since starting chemotherapy on 04/07/2026 her disease-related symptoms have improved substantially and progressively. Abdominal distension resolved after cycle 2 with no further paracentesis required since 04/2026 (she had two therapeutic taps before treatment). Early satiety resolved — she now eats full meals, and has regained 6 lb of the 14 lb she lost after her ascites was drained. Pelvic pressure and constipation resolved. **However, a new and now dominant symptom has emerged:** peripheral neuropathy beginning after cycle 2, worsening with each subsequent cycle, and now interfering with function. She describes constant numbness and burning in both feet to mid-calf and in the fingertips of both hands, with difficulty buttoning clothes, two episodes of dropping a coffee cup, and increasing unsteadiness on stairs and in the dark. She has fallen once (see below).

Current Cancer-Related Symptoms

Resolved: bloating, increasing abdominal girth, early satiety, pelvic pressure, constipation, and urinary frequency — all attributable to the ascites and peritoneal disease that have responded to treatment. **Current:** moderate fatigue (worst on days 3–7 after each infusion, improving by day 12), grade 2 peripheral neuropathy as above, alopecia (complete, expected, she wears a wig and has adjusted), and intermittent mild taste alteration. **Absent:** no pelvic or abdominal pain, no nausea or vomiting (well controlled), no vaginal bleeding or discharge, no vulvar lesion, no weight loss (weight rising), no dyspnea, no leg edema, no palpable lymphadenopathy noted by her.

3b SITE-SPECIFIC SYMPTOM REVIEW

Bleeding / Discharge Symptoms

Postmenopausal since age 52 (natural, no hormone therapy). **No postmenopausal bleeding at any point**, before or during treatment — consistent with an ovarian rather than endometrial primary. No vaginal discharge, odor, or irritation. Some vaginal dryness, discussed below under sexual health. No pelvic pain associated with any bleeding.

Pelvic Mass / Ovarian Cancer Symptoms

This was her presenting syndrome and is the relevant history: 3 months of progressive abdominal distension with a 12 lb gain from fluid, early satiety after a few bites, pelvic pressure, increased urinary frequency from mass effect, and new constipation — the classic and classically-missed constellation. She had attributed it to weight gain and menopause and had seen primary care twice before the emergency presentation. **All of these symptoms have now resolved with treatment**, which is itself a meaningful clinical response indicator. Family history is significant and detailed below.

Cervical Dysplasia / Cervical Cancer Context

Not applicable to her diagnosis, documented for completeness. Pap history: normal throughout, last co-test 2019 (negative cytology, HPV-negative), appropriately discontinued at 65 per screening guidelines. No abnormal cytology ever, no colposcopy, no LEEP or cone procedure. No postcoital bleeding. Cervix normal on examination today.

Endometrial Cancer / Hyperplasia Context

Not her diagnosis, but assessed because of the family history. No abnormal uterine bleeding ever. Postmenopausal since 52. BMI 27.4 (overweight, not obese). No PCOS. **No tamoxifen exposure.** No hormone therapy use. **Lynch syndrome risk was considered** given a paternal uncle with colon cancer, and was addressed by the germline panel (results below). No endometrial biopsy performed — no indication, no bleeding, and endometrium measured 3 mm on the diagnostic CT and ultrasound.

Vulvar / Vaginal Symptoms

No vulvar itching, burning, pain, lesion, ulcer, or mass. No vaginal bleeding or discharge. **Vaginal dryness present and troublesome**, worsened since chemotherapy began, with dyspareunia on the two occasions she has attempted intercourse with her husband of 41 years. No lichen sclerosus history. No HPV-related disease. No prior vulvar or vaginal biopsy. She raised this herself, with some hesitation, and it is addressed in the plan.

3c TREATMENT STATUS, TOXICITY & SURVEILLANCE

Treatment History

Two therapeutic paracenteses (03/24 and 04/02/2026, 4.2 L and 2.8 L). **Neoadjuvant chemotherapy: carboplatin AUC 5 plus paclitaxel 175 mg/m² every 21 days, cycles 1–4 given 04/07, 04/28, 05/19, and 06/09/2026** — then a planned 3-week gap extended to 5 weeks by a cycle-3 grade 3 neutropenia (ANC 780) requiring a one-week delay, after which pegfilgrastim was added. **Cycle 4 paclitaxel dose reduced by 20% to 140 mg/m²** for grade 2 neuropathy. No radiation, no immunotherapy, no targeted or hormonal therapy, and no clinical trial to date. No surgery yet — interval debulking is the decision at hand. No treatment discontinuation.

Current Treatment Status

Between cycle 4 (given 06/09/2026, with the interval extended for restaging) and planned interval debulking surgery. No systemic therapy currently in the body beyond residual effect. Treatment intent is **curative-intent neoadjuvant**, with 2–3 further postoperative cycles planned to complete six total, followed by maintenance therapy determined by the genetic results now available. Not on treatment hold, not palliative-only. Port in place and functioning.

Treatment Side Effects / Toxicity

Peripheral neuropathy — grade 2, the treatment-limiting toxicity. Onset after cycle 2, progressive; constant numbness and burning in both feet to mid-calf and in the fingertips; interferes with buttoning, writing, and fine manipulation; two dropped cups; unsteadiness on stairs and in the dark; **one fall on 08/02 stepping off a kerb, no fracture, bruised left hip.** Not improving in the 10 weeks since her last paclitaxel. **Other toxicities:** grade 3 neutropenia after cycle 3 (resolved with pegfilgrastim added from cycle 4, no neutropenic fever, no infection); grade 1 anemia (haemoglobin 10.3, no transfusion); grade 2 fatigue, cyclical and improving between cycles; complete alopecia, expected; grade 1 arthralgia and myalgia for 4–5 days after each infusion, acetaminophen-responsive; grade 1 taste alteration; mild constipation, controlled on a bowel regimen. **Nausea and vomiting well controlled** — no vomiting at all on her antiemetic regimen. No mucositis, no rash, no diarrhoea, no bleeding or bruising beyond the fall, no infusion reaction, no lymphedema, no tinnitus or hearing change (asked, given carboplatin), no renal or hepatic toxicity on labs.

Post-Operative History

Not applicable — no surgery yet this episode. Prior surgical history includes an open appendectomy in 1978 and a laparoscopic cholecystectomy in 2008; both are relevant to surgical planning for adhesions. No prior abdominal or pelvic malignancy surgery. No prior anaesthetic complications, and her 2008 general anaesthetic was uneventful.

Surveillance / Recurrence Symptoms

Not applicable in the surveillance sense — she has active disease under treatment, not completed treatment. Documented for the record: no new pain, no return of bloating or early satiety, no weight loss, no cough or dyspnea, no neurologic symptoms other than the neuropathy, no palpable lymph node swelling, and no bowel or bladder change. **Her symptom trajectory is one of improvement, not recurrence.**

3d REPRODUCTIVE, GENETIC, MEDICAL & SOCIAL CONTEXT

Gynecologic and Obstetric History

Menarche 13, menopause 52 (natural). **G2 P2002** — two spontaneous vaginal deliveries, 1984 and 1988, both uncomplicated. Breastfed both for approximately 8 months. Combined oral contraceptives for roughly 9 years in her

twenties and thirties (a modest protective factor against ovarian cancer, noted). No hormone therapy at menopause or since. Childbearing long complete; no fertility considerations. No prior gynecologic surgery, no fibroids, no endometriosis, no abnormal Pap, no STI history, no prior pelvic procedures apart from the two paracenteses.

Fertility / Sexual Health Considerations

Fertility preservation not applicable at 67 and postmenopausal. Ovarian function absent (postmenopausal 15 years) — so chemotherapy carried no additional menopausal consequence and bilateral oophorectomy at surgery raises no endocrine concern. **Vaginal dryness and dyspareunia are a real and under-addressed problem for her**: she and her husband have been intimate twice since diagnosis, both times painful, and she reports avoiding it since. Body image is affected by alopecia and by the anticipated abdominal scar and possible ostomy. She was visibly relieved to be asked directly, and this is addressed in the plan rather than deferred.

Genetic / Family Cancer History

Mother: ovarian cancer at 61, deceased at 63 (1994, before genetic testing was available). **Maternal aunt: breast cancer at 47.** Maternal cousin: breast cancer at 52. Paternal uncle: colon cancer at 68. Sister, 63: healthy, no cancer, and now to be offered cascade testing. Two daughters, ages 42 and 38, both healthy — and both directly affected by her results. No known BRCA or Lynch mutation in the family before now, as no relative had ever been tested. **This pedigree — ovarian cancer in her mother, two breast cancers on the maternal side, and her own high-grade serous histology — carried a high pre-test probability of a BRCA mutation**, and germline testing was appropriately sent at diagnosis. The result is now available and is documented below.

Medication and Allergy History

Oncology and supportive: pegfilgrastim 6 mg subcutaneously on day 2 of each cycle since cycle 4; ondansetron 8 mg BID PRN plus dexamethasone taper days 1–3 (highly effective — no vomiting); prochlorperazine PRN for breakthrough (used twice); polyethylene glycol daily and senna PRN for constipation; acetaminophen 650 mg PRN for arthralgia; **duloxetine 30 mg daily started 07/2026 for neuropathic pain**, with partial benefit for the burning but none for numbness. **Other:** amlodipine 5 mg for hypertension, atorvastatin 20 mg, levothyroxine 88 mcg for hypothyroidism, calcium and vitamin D3 1,000 IU. No anticoagulant, no hormone therapy, no NSAIDs (avoided on chemotherapy). **Allergies:** sulfa (rash). No infusion or hypersensitivity reaction to carboplatin or paclitaxel across four cycles — relevant, as carboplatin hypersensitivity typically emerges with later re-exposure and she will receive more.

Medical / Surgical History

Hypertension since 2014, well controlled. Hyperlipidaemia. Hypothyroidism since 2009, euthyroid on levothyroxine. Osteopenia on 2023 DEXA (T-score –1.8). No diabetes (HbA1c 5.5%). No renal disease — creatinine 0.88, eGFR 68. No liver disease. **No thromboembolic history** — relevant, since ovarian cancer carries a high VTE risk. No cardiac disease; echocardiogram 03/2026 normal with an ejection fraction of 60%. No pulmonary disease, never smoked. No autoimmune disease. Surgical: appendectomy 1978 (open), cholecystectomy 2008 (laparoscopic). No anaesthetic complications.

Social History / Support

Never smoked. Alcohol 1–2 glasses of wine weekly, none since starting chemotherapy. No substance use. Retired school principal. Married 41 years; husband is her primary caregiver, attends every visit, and attended today. Two daughters locally involved (ages 42 and 38), one accompanying her to infusions. Lives in a two-storey home — **a relevant hazard given her neuropathy and recent fall**; the stairs and bathroom have been discussed. Reliable transportation, 35 minutes from the cancer center. Medicare with a supplemental plan; no significant financial barrier, though she raised concerns about the cost of maintenance therapy. **Advance care planning: healthcare proxy completed (husband), but no advance directive or POLST** — she has requested help with this, which was arranged. Distress thermometer 5. No safety concerns at home apart from fall risk.

Pertinent Negatives

Denies heavy vaginal bleeding and any vaginal bleeding. No syncope (one mechanical fall, no presyncope). **No severe abdominal pain, no obstipation, no vomiting, and no abdominal distension — specifically assessed to exclude bowel obstruction**, a common complication in this disease. No fever, chills, or infectious symptoms (important on chemotherapy). No chest pain or severe dyspnea. **No unilateral leg swelling or calf pain** — documented given her elevated VTE risk. No focal neurologic deficit beyond symmetric distal neuropathy. Pain overall well controlled. No hopelessness or suicidal ideation on screening.

ROS GYNECOLOGIC ONCOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Gynecologic	**Positive: vaginal dryness with dyspareunia. Negative for vaginal bleeding, abnormal discharge, pelvic pain, vulvar lesion, and pelvic pressure — the last two having resolved with treatment.**
Gastrointestinal	**Positive: mild constipation controlled on a bowel regimen, grade 1 taste alteration. Negative for bloating, early satiety, nausea, vomiting, obstipation, and weight loss — all resolved; weight is rising.**
Urinary	**Negative for frequency, urgency, hematuria, pelvic pressure, and retention. Presenting frequency from mass effect has resolved.**
Constitutional	**Positive: grade 2 cyclical fatigue, worst days 3–7 post-infusion. Negative for fever, night sweats, appetite loss, and infection symptoms. Appetite recovered.**
Neurologic	**Positive: grade 2 sensory peripheral neuropathy — constant numbness and burning in both feet to mid-calf and in the fingertips, functional impairment in buttoning and writing, two dropped objects, unsteadiness, one fall 08/02. Negative for focal deficit, headache, dizziness, and cognitive change.**
Cardiopulmonary and thrombotic	**Negative for chest pain, dyspnea, palpitations, edema, unilateral leg swelling, and calf pain (VTE screening in a high-risk cancer).**
Dermatologic and infusion	**Positive: complete alopecia (expected, adjusted). Negative for rash, mucositis, bruising, bleeding, wound concerns, and any infusion reaction across four cycles.**
Psychosocial	**Positive: distress thermometer 5, anxiety about surgery and about her daughters' genetic risk, body image concerns, sexual health concerns. Negative for depression (PHQ-9 7), hopelessness, suicidal ideation, and safety concerns other than fall risk.**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE	BLOOD PRESSURE
98.2 °F	**132/78 mmHg**
HEART RATE	RESPIRATORY RATE
84 bpm, regular	**16/min**
OXYGEN SATURATION	HEIGHT

97% on room air

5′ 4″ (163 cm)

WEIGHT

159 lb (72.1 kg) — up 6 lb from the post-paracentesis nadir of 153 lb

BMI

27.4 kg/m²

BODY SURFACE AREA

1.78 m² (used for carboplatin AUC and paclitaxel dosing)

PAIN SCORE

2/10 — burning dysesthesia in the feet; no abdominal or pelvic pain

PERFORMANCE STATUS

ECOG 1 — ambulatory, self-caring, restricted in strenuous activity (was ECOG 2 at diagnosis)

5a GENERAL & SYSTEMIC EXAMINATION

General Appearance

Alert, engaged, comfortable at rest. **Markedly improved from her March presentation**, when she was distended, cachectic-appearing, and short of breath at rest. Now well nourished with restored muscle bulk in the upper arms. Complete alopecia, wearing a headscarf. Ambulates independently with a **cautious, mildly wide-based gait, watching her feet**. No distress. Husband present.

Head / Eyes / Ears / Nose / Throat

Conjunctivae pink, mild pallor at the lower lids consistent with a haemoglobin of 10.3. No scleral icterus. **Oral mucosa moist and intact with no mucositis, ulceration, or candidiasis** — specifically inspected on chemotherapy. Tongue normal, no glossitis. Dentition intact. No cervical, submandibular, or preauricular lymphadenopathy. Alopecia complete including eyebrows and lashes, expected.

Neck / Lymph Nodes

No cervical or submandibular lymphadenopathy. **No supraclavicular nodes bilaterally — specifically and carefully palpated, as left supraclavicular (Virchow) adenopathy would indicate stage IV disease and change the surgical plan.** No axillary or inguinal lymphadenopathy. No thyroid enlargement or nodule. Port site right upper chest: well healed, no erythema, no tenderness, no swelling; port palpable in normal position, accessed without difficulty at her last infusion.

Cardiovascular

Rate 84 and regular, S1 and S2 normal, no murmur, rub, or gallop. Peripheral pulses 2+ and symmetric; pedal pulses palpable despite the neuropathy. Capillary refill brisk. **No peripheral edema** — a change from her presentation, when she had 2+ lower-extremity edema from ascites and venous compression. No JVD. **No calf tenderness, unilateral swelling, or palpable cords bilaterally** — documented as VTE surveillance in a high-risk malignancy.

Pulmonary

Normal effort at rest, speaking in full sentences without pause. Clear to auscultation bilaterally with good air entry to the bases and **no reduced breath sounds, dullness, or decreased fremitus — no pleural effusion**, a change from her presentation when she had a small right effusion secondary to ascites. No crackles or wheeze. Room air.

Abdomen

The most striking change. Soft, flat, non-distended, non-tender throughout. **No ascites** — no fluid wave, no shifting dullness, no bulging flanks (at presentation she had tense ascites requiring drainage). **No palpable omental mass or caking**, which was readily palpable in March. No adnexal or pelvic mass palpable abdominally. No hepatosplenomegaly. Bowel sounds present and normal in all quadrants. No guarding, rebound, or peritoneal signs. No hernia. Well-healed right lower quadrant open appendectomy scar and laparoscopic cholecystectomy port scars — **both noted for surgical planning and adhesion risk.** No ostomy.

Breast / Chest

Screening examination performed with chaperone present, given her BRCA result (below). Breasts symmetric, no skin dimpling, retraction, or peau d'orange. **No palpable mass, thickening, or nodularity in any quadrant bilaterally.** Nipples without discharge, retraction, or excoriation. No axillary or supraclavicular adenopathy. Examination not limited. Port site

as documented above.

5b PELVIC EXAMINATION

Pelvic Exam

Performed with chaperone (Talia Brenner, MA) present, with consent, and with each step explained. External genitalia: normal hair distribution, no lesions, ulcers, or masses; no vulvar or perineal skin change. Vagina: **marked atrophic change — pale, thin, smooth mucosa with loss of rugation and reduced elasticity and calibre**, consistent with 15 years of postmenopausal status compounded by chemotherapy. No discharge, no lesion. Cervix atrophic, smooth, non-friable, no lesion, no contact bleeding. No cervical motion tenderness. **No cul-de-sac nodularity or tenderness on examination — a change from March, when the cul-de-sac was nodular and tender.** Pelvic floor normal tone. She tolerated the examination but reported discomfort on speculum insertion attributable to atrophy, which required the smallest speculum.

Speculum Exam

Small (paediatric) speculum required because of atrophy and reduced calibre. Vaginal mucosa pale, thin, and dry with petechial atrophic change but no ulceration, erosion, or granulation. Cervix visualised in full: atrophic, smooth, os stenotic, **no tumour, no friability, no bleeding source, no lesion.** No radiation change (she has had none). Scant clear secretions only. **No specimens collected** — Pap screening appropriately discontinued at 65 and there is no cytologic indication in an ovarian primary; sampling would add nothing.

Bimanual / Rectovaginal Exam

Bimanual: uterus small, atrophic, anteverted, mobile, non-tender. **Adnexa: no discrete mass palpable bilaterally** — a substantial change from March, when a firm, fixed 9 cm right adnexal mass and a smaller left mass were both readily palpable. No adnexal tenderness. **No cul-de-sac nodularity, no parametrial induration, no pelvic sidewall fixation** — each specifically assessed, as sidewall fixation would argue against resectability. **Rectovaginal examination performed** (indicated for assessing the cul-de-sac and rectovaginal septum before debulking): rectovaginal septum soft and free of nodularity, rectal mucosa smooth without mass, sphincter tone normal, no blood, stool brown and occult-blood negative. Examination not limited.

5c EXTREMITIES, SKIN, NEUROLOGIC & PSYCHIATRIC

Extremities

No edema and no lymphedema. **No calf tenderness, asymmetry, or palpable cords bilaterally.** Strength 5/5 proximally in both upper and lower limbs; **distal strength mildly reduced at 4+/5 for great-toe extension and finger abduction bilaterally — a new motor component.** Resolving ecchymosis over the left greater trochanter from the 08/02 fall, non-tender, no deformity, full hip range of motion. Nails without onycholysis or Beau lines.

Skin / Surgical Sites

Skin warm and well perfused, mildly dry. No rash, no palmar-plantar erythrodysesthesia, no drug eruption. **No petechiae, purpura, or ecchymoses apart from the resolving hip bruise** — specifically examined given the chemotherapy-related cytopenias. Complete alopecia. **Port site clean, dry, well healed, no erythema, drainage, or tenderness.** No radiation skin change. No pressure injury. Prior surgical scars well healed as documented.

Neurologic

Alert, fully oriented, fluent, no cognitive complaint or deficit. Cranial nerves II–XII intact; **hearing grossly intact to conversational voice with no tinnitus reported — assessed given carboplatin ototoxicity. Sensory: symmetric loss of light touch, pinprick, and temperature in a stocking distribution to mid-calf bilaterally and a glove distribution to the distal interphalangeal joints of all fingers. Vibration absent at both great toes and reduced at the ankles. Proprioception impaired at the toes. Monofilament insensate at 6 of 10 plantar sites bilaterally.** Motor: 4+/5 distally as above, proximally 5/5. **Deep tendon reflexes: ankle jerks absent bilaterally, knee jerks 1+, upper limb reflexes 2+.** Gait cautious and mildly wide-based; **tandem gait 3 of 10 steps; Romberg positive.** Timed Up and Go 15.2 seconds (elevated fall risk). No tremor, no focal weakness, no upper motor neuron signs.

Psychiatric

Mood appropriate, affect full and reactive, engaged and forward-looking. Cooperative and organised; she brought written questions. **Insight excellent** — she articulated the trade-off between more chemotherapy and worsening neuropathy without prompting. Tearful once, when discussing her daughters' genetic risk, and self-recovered. Judgment intact; fully

capable of surgical consent. No hopelessness, no suicidal ideation, no safety concerns. Distress thermometer 5, PHQ-9 7, GAD-7 8.

CS CANCER STAGING / DISEASE STATUS

6 ONCOLOGIC STAGING & DISEASE STATUS

Cancer type and primary site	**High-grade serous carcinoma, ovarian primary** (bilateral adnexal involvement, right dominant), with peritoneal and omental spread.
Histology and grade	High-grade serous carcinoma. Immunoprofile: p53 aberrant (diffuse strong), WT1 positive, PAX8 positive, ER positive, Ki-67 70%. Consistent with a tubo-ovarian high-grade serous primary; endometrioid, clear cell, mucinous, and metastatic gastrointestinal primaries excluded on morphology and immunoprofile.
FIGO stage / TNM stage	**FIGO stage IIIC** (pT3c pNX pM0) at diagnosis — peritoneal metastasis beyond the pelvis exceeding 2 cm with omental caking. No parenchymal liver, splenic, or pulmonary metastasis; no supraclavicular or inguinal adenopathy. Stage is assigned at diagnosis and does not change with treatment response.
Disease sites at diagnosis	Bilateral ovaries (9.2 cm right, 4.1 cm left), omentum (caking extending to the splenic hilum), peritoneum (diffuse implants, right paracolic gutter and pelvic peritoneum), small-bowel mesentery (implants), and moderate malignant ascites with positive cytology.
Biomarker or molecular testing	ER positive, PR weakly positive, p53 aberrant, WT1 and PAX8 positive, Ki-67 70%. **Somatic tumour testing: BRCA1 pathogenic variant confirmed in tumour; HRD (homologous recombination deficiency) positive with a genomic instability score of 62.** MSI stable, MMR proteins retained. No other actionable alteration. HER2 not applicable.
Genetic testing results	**Germline multigene panel: pathogenic BRCA1 variant, c.5266dupC (p.Gln1756Profs), heterozygous — a well-characterised founder mutation. Reported 05/2026. No other pathogenic or likely-pathogenic variant; no Lynch-associated mutation. This result carries major implications for prognosis, maintenance therapy, and cascade testing in her sister and two daughters.**
Initial versus recurrent disease	**Initial disease — first presentation, currently on first-line neoadjuvant therapy. No recurrence.**
Treatment intent	**Curative intent — neoadjuvant chemotherapy, planned interval debulking surgery, adjuvant completion chemotherapy, then maintenance therapy. Not palliative.**
Response status	**Partial response by RECIST 1.1 — 62% reduction in the sum of target lesion diameters, complete resolution of ascites, and a 96% fall in CA-125 from 1,842 to 68 U/mL. No new lesions and no progression at any site. An excellent chemosensitive response, consistent with**

	BRCA1-mutated, HRD-positive biology.
Date and source of staging information	Staging established 03/24–03/31/2026 from CT chest, abdomen, and pelvis with contrast, ascitic fluid cytology, and image-guided omental core biopsy. Restaging CT performed 08/17/2026 (results below) after cycle 4. Surgical staging pending at interval debulking.
Limitations or pending results	Peritoneal disease is inherently under-measured on CT — small-volume miliary implants are frequently occult radiologically, so the true residual burden will only be known at laparotomy. Nodal status remains NX pending surgical assessment. No pending pathology or molecular results.

TT TREATMENT / TOXICITY ASSESSMENT

7 CURRENT TREATMENT PLAN & TOXICITY MONITORING

Current regimen and cycle number	Carboplatin AUC 5 plus paclitaxel every 21 days — 4 of a planned 6 cycles complete, with cycle 4 paclitaxel dose-reduced 20% to 140 mg/m² for neuropathy. Currently between cycle 4 and planned interval debulking.
Last and next treatment date	Last chemotherapy 06/09/2026 (cycle 4). Interval extended deliberately for restaging and surgical planning. Next step is surgery rather than chemotherapy, with cycles 5 and 6 to follow postoperatively.
Dose modifications, delays, or holds	One 7-day delay before cycle 4 for grade 3 neutropenia (ANC 780), with pegfilgrastim added thereafter and no further delay. Paclitaxel reduced 20% at cycle 4 for grade 2 neuropathy. Carboplatin unchanged — renal function stable and it is not the neurotoxic agent here. No hold.
Treatment response	Excellent partial response — CA-125 1,842 to 68 U/mL (96% fall), 62% target-lesion reduction, complete resolution of ascites, resolution of omental caking on palpation, and resolution of all disease-related symptoms. ECOG improved from 2 to 1.
Side effects and grade	Peripheral sensory neuropathy grade 2 (CTCAE — moderate symptoms limiting instrumental activities of daily living), now with a mild motor component. Neutropenia grade 3 (cycle 3, resolved with growth factor support). Anemia grade 1. Fatigue grade 2. Alopecia grade 2. Arthralgia and myalgia grade 1. Taste alteration grade 1. Constipation grade 1. No grade 4 toxicity and no hospitalisation.
Neuropathy assessment	The treatment-limiting toxicity and the central management problem. Grade 2 sensory with emerging motor involvement: stocking-glove sensory loss, absent vibration at the toes, absent ankle jerks, impaired proprioception, 4+/5 distal strength, Romberg positive, tandem gait 3 of 10 steps, Timed Up and Go 15.2 s, monofilament insensate at 6 of 10 plantar sites, and one fall. Duloxetine gives partial benefit for burning but none for numbness. Not improving 10 weeks after the last paclitaxel — which materially changes the calculus for

	cycles 5 and 6.
Nausea and vomiting control	**Excellent — no vomiting across four cycles** and only mild day-2 to day-3 nausea on ondansetron with a dexamethasone taper; prochlorperazine needed twice. Regimen effective and unchanged.
Bowel function	Grade 1 constipation, controlled on daily polyethylene glycol with senna PRN. **No obstructive symptoms — no obstipation, vomiting, or distension**, specifically assessed given her peritoneal disease. Occult blood negative on today's rectal examination.
Cytopenia symptoms	Mild fatigue and pallor attributable to a haemoglobin of 10.3. **No neutropenic fever, no infection, no bleeding or petechiae.** Pegfilgrastim from cycle 4 has controlled the neutropenia (nadir ANC improved from 780 to 1,650).
Infection risk	Moderate on chemotherapy, mitigated by growth factor support. No infection to date. Counselled repeatedly on fever above 100.4 °F as an emergency. Influenza and COVID-19 vaccinations current; pneumococcal given 2024.
Thromboembolic risk	**Elevated** — ovarian cancer, planned major abdominal surgery, and a port in situ, though she is ambulatory and has no personal or family history. Khorana score 2 (intermediate). No prophylactic anticoagulation antepartum to surgery; **extended postoperative prophylaxis for 28 days is planned**. Examined for DVT today — negative.
Organ toxicity monitoring	Renal: creatinine 0.88, eGFR 68 — stable, carboplatin dosing unchanged. Hepatic: AST 24, ALT 21, bilirubin normal. Cardiac: no cardiotoxic agent in this regimen; echocardiogram 03/2026 normal (EF 60%). Pulmonary: no toxicity, clear examination. **Otologic: no tinnitus or hearing change — asked specifically given carboplatin.** Endocrine: TSH normal on levothyroxine; no immunotherapy, so no immune endocrinopathy risk.
Port or line status	Right chest implanted port, placed 04/03/2026. Site well healed, no erythema, tenderness, or swelling; accessed without difficulty and flushing well. **To remain in situ through surgery, adjuvant cycles 5 and 6, and maintenance therapy.**
Supportive medications and adherence	Full adherence reported and corroborated by pharmacy fills. Pegfilgrastim, antiemetics, bowel regimen, duloxetine, and all non-oncologic medications taken as prescribed. No missed doses. She keeps a written medication and symptom diary, which she brought.
Patient tolerance and functional impact	Overall tolerance good with one clear exception. **ECOG improved 2 to 1** and disease symptoms have resolved, but neuropathy now limits fine motor tasks, driving at night, and safe stair use, and has caused one fall. She stated plainly that she wants surgery and is willing to accept more chemotherapy, but asked whether the numbness will become permanent — the honest answer being that grade 2 neuropathy present 10 weeks after the last dose carries a real risk of partial permanence.

PR PROCEDURES PERFORMED

8 PROCEDURE DOCUMENTATION

Procedure, indication, consent, chaperone, anaesthesia

Pelvic examination with bimanual and rectovaginal assessment, performed today. Indication: pre-operative assessment of residual pelvic disease, cul-de-sac nodularity, rectovaginal septum involvement, and pelvic sidewall fixation before interval debulking — findings that directly inform surgical approach and the likelihood of achieving complete cytoreduction. Verbal consent obtained; chaperone Talia Brenner, MA present throughout. No anaesthesia; a paediatric speculum was required because of atrophy. Also performed: **port site assessment** and a **screening breast examination** (newly indicated by her BRCA1 result). **Chemotherapy consent discussion for cycles 5 and 6, and surgical consent discussion for interval debulking**, both conducted and documented.

Technique, specimens, findings

Systematic external, speculum, bimanual, and rectovaginal examination as documented in the Objective section. Key findings: no palpable adnexal mass bilaterally (previously a fixed 9 cm right mass), **no cul-de-sac nodularity or tenderness** (previously nodular and tender), no parametrial induration, no pelvic sidewall fixation, soft non-nodular rectovaginal septum, and marked vaginal atrophy. **No specimens obtained** — no cervical cytology (screening appropriately discontinued at 65 and no indication in an ovarian primary), no endometrial sampling (no bleeding, endometrium 3 mm), and no biopsy (no lesion). Stool occult blood negative.

Tolerance, complications, aftercare, follow-up

Tolerated with mild discomfort on speculum insertion related to atrophy; no bleeding and no vasovagal response. **No complications.** Findings and their favourable surgical implications were explained to her and her husband immediately, which she described as the most reassuring part of the visit. Aftercare: no restrictions; vaginal moisturiser recommended (see plan). Follow-up: pre-operative anaesthesia assessment within 1 week, surgery within 3–4 weeks.

SV SURVEILLANCE ASSESSMENT

9 CANCER SURVEILLANCE DETAILS

Applicability	**Not applicable in the post-treatment sense — she has active disease on first-line therapy, not completed treatment. Section retained to document the surveillance framework that will apply after she completes surgery, adjuvant chemotherapy, and enters maintenance therapy, and to record that recurrence symptoms were actively reviewed.**
Cancer type and treatment completion date	**High-grade serous ovarian carcinoma, stage IIIC. Treatment not complete — surgery and cycles 5 and 6 pending, then maintenance. Anticipated completion of cytotoxic therapy late 2026.**
Symptoms of recurrence reviewed	**Reviewed in full today and all negative: no return of bloating or abdominal distension, no early satiety, no new pelvic or abdominal pain, no weight loss, no cough or dyspnea, no palpable lymphadenopathy, no bowel or bladder change. Her trajectory is one of continued improvement.**
Physical exam findings	**No ascites, no palpable omental mass, no adnexal mass, no cul-de-sac nodularity, no lymphadenopathy including no supraclavicular nodes — a comprehensively improved**

	examination compared with March.
Tumour marker trends	**CA-125: 1,842 (03/2026) to 604 (post-cycle 1) to 218 (post-cycle 2) to 96 (post-cycle 3) to 68 U/mL (08/17/2026, post-cycle 4).** A 96% fall with a normalising trajectory — a strong favourable prognostic indicator. HE4 also falling (from 412 to 78 pmol/L).
Imaging results and timing	Restaging CT chest, abdomen, and pelvis 08/17/2026 — partial response, detailed in the laboratory section. Diagnostic CT 03/2026 for comparison. Post-treatment surveillance imaging schedule to be set after adjuvant therapy.
Cytology surveillance	Not applicable — Pap screening appropriately discontinued at 65, and cervical cytology has no role in ovarian cancer surveillance. Documented to record that this was considered rather than overlooked.
Late treatment effects	**Already emerging: grade 2 peripheral neuropathy with a real risk of partial permanence.** Also anticipated: fatigue, vaginal atrophy (present and now compounded), osteopenia progression (T-score –1.8 in 2023, and surgical oophorectomy adds nothing endocrine at 15 years postmenopausal), and cognitive complaints (none reported). Alopecia expected to reverse.
Lymphedema status	None currently. Lower-extremity lymphedema risk will rise after pelvic and para-aortic lymphadenectomy at debulking — counselled pre-emptively, with baseline limb circumferences to be recorded before surgery.
Sexual health and menopausal symptoms	**Active problem, patient-raised:** marked vaginal atrophy with dyspareunia and consequent avoidance of intimacy after 41 years of marriage. Postmenopausal 15 years, no hormone therapy. Addressed directly in the plan rather than deferred, as it too often is in this population.
Survivorship care needs	To be formalised after adjuvant therapy: a written survivorship plan covering neuropathy rehabilitation, bone health, sexual health, lymphedema surveillance, cardiovascular risk, **BRCA1-related breast surveillance (annual mammography with MRI, and a risk-reducing mastectomy discussion)**, and psychosocial support. Initiated conceptually today.
Health maintenance and screening needs	**Annual breast MRI and mammography now indicated by her BRCA1 status** — first MRI ordered today. Colonoscopy 2021 normal, next due 2031. DEXA due (last 2023, T-score –1.8). Influenza, COVID-19, and pneumococcal vaccinations current; shingles series to be completed. Dental review before surgery.
Next surveillance plan	Governed by the treatment plan rather than surveillance at present: interval debulking in 3–4 weeks, cycles 5 and 6 postoperatively, then **PARP inhibitor maintenance** given the BRCA1 mutation and HRD-positive status. Formal surveillance — examination and CA-125 every 3 months for 2 years, then every 6 months, with imaging as clinically indicated — begins once cytotoxic therapy completes.

ST SCREENING / ASSESSMENT TOOLS

10 STANDARDIZED TOOLS & INTERPRETATION

ECOG performance status	**1 — ambulatory, self-caring, restricted in strenuous activity. Improved from 2 at diagnosis** (then ambulatory but up less than 50% of waking hours, limited by ascites and dyspnea). A favourable indicator of surgical candidacy.
Karnofsky performance status	**80% — able to carry on normal activity with effort, some signs of disease. Concordant with ECOG 1; improved from 60% at diagnosis.**
Distress thermometer	**5 of 10 — moderate. Problem list she checked: fatigue, tingling in hands and feet, worry, fear, sexual health concerns, and appearance. Down from 8 at diagnosis. Referral thresholds met and psycho-oncology already engaged.**
PHQ-9	**7 — mild depressive symptoms, sleep and fatigue items predominant. Item 9 = 0. Prior 04/2026: 11. Improving alongside her physical recovery.**
GAD-7	**8 — mild-to-moderate anxiety. Content specific: surgery, whether the neuropathy is permanent, and her daughters' genetic risk. Down from 13 at diagnosis.**
Pain scale	**2/10 — burning dysesthesia in the feet only. No abdominal or pelvic pain** (was 5/10 at diagnosis). Neuropathic rather than nociceptive in character, which is why duloxetine rather than an opioid is the appropriate agent.
Neuropathy assessment scale	**CTCAE grade 2 sensory neuropathy with an emerging motor component. Patient Neurotoxicity Questionnaire: moderate-to-severe on both sensory items. Monofilament insensate at 6 of 10 plantar sites bilaterally. Trajectory is the concern — no improvement 10 weeks after the last paclitaxel dose.**
Nutrition screening	**MUST score 0 — low risk. Weight rising (159 lb, up 6 lb from nadir)**, appetite restored, albumin 3.8, prealbumin normal. A marked improvement from the malnutrition risk at diagnosis, and favourable for surgical healing.
Fall risk screening	**Elevated and now the leading safety issue.** Timed Up and Go 15.2 seconds (threshold 12), Romberg positive, tandem gait 3 of 10 steps, absent ankle jerks, impaired proprioception, **one fall on 08/02**, and a two-storey home. Formal fall-prevention intervention triggered.
Lymphedema assessment	**No lymphedema currently; limb circumferences symmetric. Baseline measurements to be recorded before lymphadenectomy so any postoperative change can be quantified.**
Sexual function / vaginal health questionnaire	**Vaginal Assessment Scale: moderate-to-severe dryness, dyspareunia, and reduced elasticity. FSFI not formally administered; she reports two painful attempts at intercourse and subsequent avoidance. Documented because she raised it and because it is frequently omitted from oncology notes.**

	from oncology notes.
Social determinants of health screening	**Negative for housing, food, transportation, and utility insecurity. Medicare with supplemental coverage. Positive for anticipated financial concern about PARP inhibitor maintenance costs — financial counselling and manufacturer assistance initiated.**
Advance care planning assessment	**Healthcare proxy completed (husband); no advance directive or POLST in place — a gap she identified herself and asked for help with. Palliative care is already co-managing symptoms, and a goals-of-care and documentation session is scheduled. Framed explicitly as prudent planning in a curative-intent course, not a prognostic signal — a distinction she appreciated.**

L LABORATORY AND DIAGNOSTIC RESULTS

11 RESULTS REVIEWED OR ORDERED

Pathology

Omental core biopsy 03/28/2026: high-grade serous carcinoma. Immunohistochemistry: p53 aberrant (diffuse strong nuclear), WT1 positive, PAX8 positive, ER positive, PR weakly positive, Ki-67 70%, CK7 positive, CK20 negative, CDX2 negative — confirming a tubo-ovarian high-grade serous primary and excluding a metastatic gastrointestinal primary. **Ascitic fluid cytology 03/24 and 04/02:** malignant cells consistent with serous carcinoma, both specimens. No surgical pathology yet — staging specimens, margins, lymphovascular invasion, nodal status, and chemotherapy response score all pending at interval debulking. No pending outside pathology.

Tumour Markers

CA-125: 1,842 (03/24/2026) to 604 to 218 to 96 to 68 U/mL (08/17/2026) — a 96% reduction with a consistent downward trajectory. Normal is under 35, so she is approaching but has not reached normalisation, which is typical at this point and does not diminish the response. **HE4: 412 to 78 pmol/L.** CEA 1.8 and CA 19-9 12 (both normal at diagnosis and unchanged — obtained then to help exclude a gastrointestinal primary). Beta-hCG, AFP, LDH, and inhibin normal and not applicable to this histology. **Interpretation: the CA-125 trend is one of the strongest available predictors of chemosensitivity and of the likelihood of complete cytoreduction, and hers is excellent.**

Treatment Monitoring Labs (08/17/2026)

CBC: **haemoglobin 10.3 g/dL** (grade 1 anemia, up from a 9.6 nadir), **WBC 4.8 with ANC 2,940** (recovered — nadir was 780 at cycle 3 before growth factor support), platelets 212,000, MCV 88. CMP: sodium 139, potassium 4.2, **creatinine 0.88 with eGFR 68** (stable; carboplatin dosing unchanged), calcium 9.2, magnesium 1.8, albumin 3.8, total protein 6.9. Liver: **AST 24, ALT 21**, alkaline phosphatase 88, bilirubin 0.7 — all normal. Coagulation: PT, INR, and aPTT normal (relevant pre-operatively). Urinalysis unremarkable. TSH 1.7 on levothyroxine. HbA1c 5.5%. Iron studies: ferritin 42, transferrin saturation 18% — mild iron deficiency contributing to the anemia. **No grade 3 or 4 laboratory abnormality; she is fit for surgery.**

Imaging

Restaging CT chest, abdomen, and pelvis with contrast, 08/17/2026: right adnexal mass reduced from 9.2 to 3.4 cm; left adnexal mass from 4.1 to 1.6 cm; **omental caking largely resolved with residual soft-tissue stranding only, no longer extending to the splenic hilum**; peritoneal implants markedly reduced, the largest from 2.8 cm to 0.9 cm; small-bowel mesenteric implants no longer discretely measurable; **complete resolution of ascites**; the small right pleural effusion has resolved. No new lesion. No parenchymal liver, splenic, or pulmonary metastasis. No retroperitoneal, pelvic, or supraclavicular lymphadenopathy exceeding 1 cm. No hydronephrosis. **Impression: partial response by RECIST 1.1 (62% reduction in the sum of target diameters). Findings are consistent with resectable residual disease and support proceeding to interval debulking.** Radiology explicitly cautioned that small-volume peritoneal implants are frequently under-detected on CT, so the true burden will be defined at laparotomy. Chest imaging clear. No PET/CT or bone scan — neither indicated. Diagnostic 03/2026 CT reviewed side by side for comparison.

Genetic / Molecular Testing

Germline multigene panel (05/2026): pathogenic BRCA1 variant c.5266dupC (p.Gln1756Profs), heterozygous — a well-characterised loss-of-function founder mutation. No other pathogenic or likely-pathogenic variant across the panel; no Lynch-associated mutation, consistent with MMR-retained, MSI-stable tumour testing. **Somatic tumour testing: BRCA1 pathogenic variant confirmed in tumour; HRD positive with a genomic instability score of 62 (positive threshold 42).** MSI stable, MMR proteins retained (MLH1, MSH2, MSH6, PMS2 all preserved). No HER2, ER/PR-directed, PD-L1, or NTRK indication. **Clinical consequence: BRCA1-mutated and HRD-positive status predicts platinum sensitivity (borne out by her response) and makes PARP inhibitor maintenance clearly indicated after completion of chemotherapy — the single most impactful result of her whole workup.** Cascade testing indicated for her sister and both daughters.

Procedure / Operative Records

No cytoreductive operative record yet — interval debulking pending. Records available: two therapeutic paracentesis procedure notes (4.2 L on 03/24, 2.8 L on 04/02, both without complication), the image-guided omental core biopsy note (03/28, no complication), and the port placement note (04/03/2026, right internal jugular approach, no complication). Historical: 1978 open appendectomy and 2008 laparoscopic cholecystectomy — **both flagged for the surgical team as adhesion risks.** Staging procedure details, lymph node assessment, debulking status, and residual disease to be documented at surgery.

Prior Records Reviewed

Emergency department record from 03/24/2026 with the presenting CT. All four chemotherapy administration records with dose, toxicity grading, and the documented cycle-3 delay and cycle-4 dose reduction. Complete laboratory trend from 03/2026 to date. Genetics consultation note and both germline and somatic reports. Psycho-oncology and palliative care notes. Nutrition assessment. 03/2026 echocardiogram (EF 60%). Primary care records confirming hypertension, hyperlipidaemia, hypothyroidism, and the 2023 DEXA. 2021 colonoscopy report (normal). Pharmacy fill history confirming full adherence. The patient's own medication and symptom diary.

A ASSESSMENT

12 GYNECOLOGIC ONCOLOGY CLINICAL INTERPRETATION

- **High-grade serous ovarian carcinoma, FIGO stage IIIC, BRCA1-mutated and HRD-positive, with an excellent partial response to four cycles of neoadjuvant carboplatin and paclitaxel.** CA-125 has fallen 96% from 1,842 to 68 U/mL, restaging CT shows a 62% reduction in target lesions with complete resolution of ascites and near-resolution of omental caking, and every disease-related symptom has resolved. Treatment intent remains curative.
- **She is now a good candidate for interval debulking surgery, and the evidence for it is convergent:** radiologic partial response with residual disease that appears resectable, a normalising CA-125 trajectory (one of the strongest predictors of complete cytoreduction), resolution of ascites, a pelvic examination that has converted from a fixed 9 cm mass with a nodular tender cul-de-sac to no palpable mass and no nodularity or sidewall fixation, performance status improved from ECOG 2 to 1, weight and albumin restored, and no grade 3 or 4 laboratory abnormality. **The realistic goal is complete gross resection, which is the single most important modifiable determinant of survival in this disease.**
- **Grade 2 chemotherapy-induced peripheral neuropathy is the dominant toxicity and the central management dilemma.** Stocking-glove sensory loss to mid-calf and to the fingertips, absent ankle jerks, absent vibration at the toes, impaired proprioception, an emerging motor component at 4+/5 distally, Romberg positive, Timed Up and Go 15.2 seconds, monofilament insensate at 6 of 10 plantar sites, **and one fall**. Critically, it has not improved in the 10 weeks since her last paclitaxel — which raises the real prospect of partial permanence and directly shapes the decision about cycles 5 and 6.

- **The competing considerations for adjuvant chemotherapy were weighed explicitly.** Completing six cycles is standard and her disease is manifestly chemosensitive; but further paclitaxel at any dose risks converting a grade 2 neuropathy into a grade 3 disability in a 67-year-old who has already fallen once. **The resolution is to proceed with two postoperative cycles using carboplatin with a further-reduced or omitted paclitaxel, decided after surgery on the basis of the interval neuropathy trajectory and the chemotherapy response score on the surgical specimen** — and she was told this plainly rather than promised a fixed plan.
- **The BRCA1 pathogenic variant is the most consequential single result of her entire workup, and it operates on four fronts:** it explains her marked platinum sensitivity; it makes **PARP inhibitor maintenance clearly indicated** after completion of chemotherapy, with a substantial progression-free survival benefit in this exact population; it confers a high lifetime breast cancer risk requiring annual MRI and mammography and a risk-reducing mastectomy discussion; and it mandates **cascade testing for her sister and both daughters**, for whom a positive result would change screening and prophylactic options in their forties.
- **Differential diagnosis at presentation was resolved and is worth recording:** a primary peritoneal or fallopian tube high-grade serous carcinoma remains within the same disease family and management pathway; a metastatic gastrointestinal primary was excluded by CK7-positive, CK20-negative, CDX2-negative immunoprofile with normal CEA and CA 19-9 and a normal 2021 colonoscopy; endometrial, clear cell, mucinous, and endometrioid histologies were excluded morphologically and immunophenotypically; benign causes of ascites (cirrhosis, heart failure, tuberculous peritonitis) were excluded by positive cytology, imaging, and normal cardiac and hepatic assessment; and lymphoma was excluded on biopsy.
- **Elevated and clinically actionable fall risk** — the intersection of neuropathy, a positive Romberg, a Timed Up and Go of 15.2 seconds, absent ankle reflexes, one fall on 08/02, and a two-storey home. In an older adult on active treatment, a hip fracture would derail her cancer care entirely, so this warrants intervention in its own right rather than being noted in passing.
- **Genitourinary syndrome of menopause with dyspareunia** — marked vaginal atrophy on examination in a woman postmenopausal 15 years, compounded by chemotherapy, causing dyspareunia and avoidance of intimacy in a 41-year marriage. She raised it herself. This is treatable, is routinely omitted from oncology documentation, and is being addressed. **Non-hormonal measures first, with low-dose vaginal estrogen a defensible option in an ER-positive but non-breast, non-endometrial malignancy after multidisciplinary discussion.**
- **Other active issues:** grade 1 anemia with mild iron deficiency (ferritin 42, saturation 18%) worth correcting before major surgery; controlled grade 3 neutropenia history now managed with pegfilgrastim; elevated VTE risk (Khorana 2) requiring extended postoperative prophylaxis; osteopenia (T-score –1.8, DEXA due); moderate but improving psychological distress (thermometer 5, PHQ-9 7, GAD-7 8, all down from diagnosis); and **advance care planning incomplete — proxy in place but no directive or POLST**, which she asked to address.
- **No indication for urgent escalation.** No bowel obstruction, no VTE, no neutropenic fever, no uncontrolled pain, no bleeding, no progression at any site, and no new lesion. Everything here is planned and elective. **Recommendation: proceed to interval debulking within 3–4 weeks, with adjuvant chemotherapy and PARP maintenance to follow, alongside active management of the neuropathy, fall risk, sexual health, anemia, and advance care planning.**

P PLAN

13 MANAGEMENT BY PROBLEM

- **Interval debulking surgery — the central decision, and she is proceeding.** Planned within 3–4 weeks (target 09/14/2026): exploratory laparotomy with total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, peritoneal stripping, pelvic and para-aortic lymph node assessment, and any additional resection required for complete gross cytoreduction. **Goal stated explicitly to her: complete gross resection (R0), the strongest modifiable determinant of survival.** Risks, benefits, and alternatives discussed in full and documented: bleeding and transfusion, infection, ureteral or bladder injury, bowel injury with a possible **bowel resection and stoma (approximately 15–25% in this setting — discussed candidly, as she asked directly)**,

VTE, anastomotic leak, prolonged ileus, wound complication, incisional hernia, anaesthetic risk, and the possibility that unresectable disease is found and the operation is abandoned. Alternatives (further chemotherapy first, or no surgery) were presented and declined. She consented. **Pre-operative: anaesthesia assessment within 1 week, ERAS protocol with carbohydrate loading and no prolonged fasting, mechanical bowel preparation, type and screen with two units cross-matched, dental review, and stoma nurse counselling with pre-operative siting given the resection possibility.**

- **Peripheral neuropathy — escalated management, and honest counselling. No further paclitaxel before surgery**, and the decision on cycles 5 and 6 deferred until after surgery, based on the interval neuropathy trajectory and the chemotherapy response score on the specimen: options are carboplatin alone, carboplatin with a further-reduced paclitaxel, or a switch of partner agent. She was told plainly that grade 2 neuropathy persisting 10 weeks after the last dose carries a real risk of partial permanence, and that this is exactly why we are not simply pushing on. **Duloxetine increased from 30 mg to 60 mg daily** (the agent with the best evidence in this setting, and it has already partly helped the burning). **Occupational therapy referral** for fine-motor adaptation — button hooks, built-up handles, adaptive utensils. **Physical therapy referral** for balance, proprioceptive retraining, and safe stair technique. No gabapentin added at present to avoid compounding sedation and fall risk. Neuropathy graded formally at every visit.
- **Fall prevention — treated as a priority, not an aside.** Timed Up and Go 15.2 s, Romberg positive, absent ankle jerks, and one fall on 08/02 in a two-storey home. **Home safety evaluation ordered** (grab bars, stair rails on both sides, removal of loose rugs, night lighting, non-slip bathroom surfaces). Supportive well-fitting footwear with firm soles; no barefoot walking and no slippers. Cane prescribed for outdoor and low-light use, with PT to fit and train. Counselled not to drive at night. Medication review for sedating agents — none identified beyond duloxetine, which is being titrated cautiously. **Framed for her explicitly: a hip fracture now would derail her cancer treatment entirely.**
- **PARP inhibitor maintenance — planned and now clearly indicated.** Given the germline BRCA1 pathogenic variant and HRD-positive status, PARP inhibitor maintenance is to start after completion of adjuvant chemotherapy and recovery from surgery, with a substantial progression-free survival benefit in precisely this population. Counselled on the expected duration (approximately 2 years), the need for monthly CBC monitoring, common toxicities (anemia, nausea, fatigue), and the rare risk of myelodysplastic syndrome. **Insurance authorisation and manufacturer assistance initiated today** in response to her stated cost concern, well ahead of need. Bevacizumab discussed and deferred — PARP monotherapy is the stronger choice in BRCA-mutated disease and avoids the wound-healing and perforation risks around surgery.
- **Genetic counselling and cascade testing — actively pursued.** Germline BRCA1 c.5266dupC explained in full to her and her husband, with the genetic counsellor's report reviewed together. **Cascade testing arranged for her sister (63) and both daughters (42 and 38)**, with a family letter and the specific variant details provided so their clinicians can test directly; the genetics team will contact them with her consent. Implications for her daughters discussed — breast MRI from age 25–30, risk-reducing salpingo-oophorectomy discussion around 35–40, and prophylactic mastectomy as an option. **Her own BRCA1-related breast surveillance begins now: annual breast MRI ordered** (first within 3 months, timed to avoid the perioperative period), alternating with mammography, and a risk-reducing mastectomy discussion deferred until after she completes cancer treatment. Her tearfulness about her daughters was acknowledged directly, and she was reminded that this knowledge is protective for them.
- **Adjuvant chemotherapy plan.** Two further cycles (5 and 6) to begin 4–6 weeks after surgery once wound healing is adequate, with the regimen individualised as above. Continue pegfilgrastim from the first postoperative cycle given the prior grade 3 neutropenia. Antiemetic regimen unchanged — it has worked perfectly. Lab monitoring before each cycle. Criteria for hold reviewed: ANC below 1,500, platelets below 100,000, grade 3 neuropathy, or unresolved surgical complication. Carboplatin hypersensitivity risk on re-exposure explained, with premedication and a monitored infusion.
- **Radiation oncology — not indicated.** Radiotherapy has no established role in stage IIIC high-grade serous ovarian carcinoma in this setting, and no referral is being made. Documented explicitly so it is clear this was considered and excluded rather than overlooked. Vaginal dilator counselling, which would accompany pelvic radiotherapy, is not applicable — her vaginal symptoms are atrophic and are addressed separately below.

- **Anemia and iron deficiency — corrected before surgery.** Haemoglobin 10.3 with ferritin 42 and transferrin saturation 18%. **Intravenous iron ordered pre-operatively** — correcting iron stores before a major cytoreductive operation reduces transfusion need, and oral iron would be too slow and poorly tolerated alongside her bowel regimen. Repeat CBC and ferritin before surgery. No erythropoiesis-stimulating agent (contraindicated in curative-intent malignancy). Two units cross-matched for theatre.
- **VTE prophylaxis.** Khorana score 2 with major abdominal surgery ahead. No antepartum anticoagulation now; **perioperative mechanical prophylaxis plus extended pharmacologic prophylaxis for 28 days postoperatively**, which is the evidence-based duration after cytoreductive surgery for ovarian cancer. Counselled on calf pain, unilateral swelling, dyspnea, and chest pain as present-now symptoms. Port to remain in situ through maintenance therapy.
- **Sexual health and genitourinary syndrome of menopause — addressed, not deferred.** She raised it, and it is treatable. Non-hormonal first line: a vaginal moisturiser used regularly (not only before intercourse) and a silicone-based lubricant. Vaginal dilator therapy with pelvic floor physiotherapy for the reduced calibre and to make examinations tolerable. **Low-dose vaginal estrogen discussed as a reasonable option** — her tumour is ER-positive but this is neither breast nor endometrial cancer, systemic absorption from low-dose vaginal preparations is minimal, and the quality-of-life benefit is real; decision deferred to after surgery with multidisciplinary input, and she was given the reasoning rather than a flat refusal. Couples-based sexual health counselling offered and accepted; her husband was present for this discussion at her request.
- **Supportive and palliative care — concurrent, and named as such.** Palliative care (Dr. Marchetti) continues co-management for neuropathic pain, fatigue, and symptom control — **explicitly framed as concurrent supportive care in a curative-intent treatment course, not end-of-life care**, a distinction she found reassuring. **Advance care planning: she asked for help, and a session is scheduled with palliative care and her husband to complete an advance directive and POLST** alongside the existing healthcare proxy, framed as prudent planning before major surgery for anyone her age. Psycho-oncology continues (distress thermometer 5, PHQ-9 7, GAD-7 8, all improving). Nutrition follow-up to maintain her weight gain and optimise protein intake before surgery. Social work engaged for financial navigation. Ovarian cancer peer support group information provided.
- **Referrals and coordination.** Anaesthesia (pre-operative), stoma nurse (pre-operative siting and counselling), occupational therapy (fine motor), physical therapy (balance and gait), home safety evaluation, interventional radiology not required, genetics (cascade testing), breast imaging (BRCA1 surveillance MRI), nutrition, psycho-oncology, palliative care, social work, and financial counselling. **Coordination note sent today to Dr. Weatherby (primary care) summarising the response, the BRCA1 result with its implications for family screening, the surgical plan, the neuropathy, and the fall risk.** Tumour board presentation scheduled to confirm the surgical plan and the maintenance strategy.
- **Patient and family education.** All of her written questions answered with her husband present. Explained: what a partial response means and why it makes surgery worthwhile now; what complete gross resection means for her prognosis; why the neuropathy is limiting further paclitaxel and what its likely trajectory is (honestly — partial permanence is possible); what the BRCA1 result means for her treatment and for her daughters; and what PARP maintenance involves. Written summary, medication list, and a symptom card provided; teach-back confirmed. **Instructed to seek emergency care for fever above 100.4 °F, severe abdominal pain with vomiting or inability to pass stool or gas (bowel obstruction), chest pain, severe shortness of breath, unilateral leg swelling or calf pain, uncontrolled bleeding, or a fall with injury; and to call the clinic for worsening numbness or new weakness, another fall, port site redness or tenderness, or any question at all.** Direct clinic and 24-hour oncology numbers given.

F FOLLOW-UP

14 REASSESSMENT PLAN

Follow-up

Pre-operative anaesthesia assessment within 1 week, with stoma nurse counselling and siting, dental review, and repeat CBC, CMP, coagulation studies, and ferritin before theatre. Intravenous iron within 1–2 weeks. **Interval debulking surgery**

targeted for 09/14/2026 at this centre. Post-operative check at 2 weeks for wound review, pathology discussion including the chemotherapy response score, and neuropathy re-grading; **adjuvant cycles 5 and 6 beginning 4–6 weeks post-operatively with the regimen individualised on the neuropathy trajectory.** CA-125 before surgery and before each subsequent cycle. Occupational and physical therapy within 2 weeks, home safety evaluation before surgery. Genetics cascade-testing contact with her sister and daughters within 4 weeks. Breast MRI within 3 months, timed away from the perioperative period. Advance care planning session with palliative care and her husband before surgery. **PARP inhibitor maintenance after completion of chemotherapy, with authorisation already in progress.** Formal surveillance — examination and CA-125 every 3 months — begins once cytotoxic therapy completes. Immediate contact for fever, obstructive symptoms, VTE symptoms, a further fall, or new weakness.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

84 minutes

ONCOLOGY COUNSELING TIME

24 minutes — response interpretation, prognosis, neuropathy trajectory and permanence risk

TREATMENT PLANNING TIME

16 minutes — adjuvant regimen individualisation, PARP maintenance sequencing

CHEMOTHERAPY / SYSTEMIC THERAPY COUNSELING TIME

11 minutes — cycles 5 and 6, dose modification, hold criteria, carboplatin hypersensitivity risk

SURGICAL COUNSELING TIME

19 minutes — interval debulking consent, R0 goal, stoma possibility, ERAS

GENETIC COUNSELING COORDINATION TIME

8 minutes — BRCA1 implications, cascade testing for sister and two daughters, breast surveillance

CARE COORDINATION TIME

13 minutes — anaesthesia, stoma nurse, OT/PT, genetics, breast imaging, palliative care, financial

RECORDS REVIEW TIME

14 minutes — restaging CT side-by-side comparison, four cycle records, germline and somatic reports

PROCEDURE TIME

12 minutes — pelvic examination with bimanual and rectovaginal assessment, port and breast examination

E/M LEVEL

99215 — established patient, high-complexity medical decision making (84 minutes total time on the date of service)

PROCEDURE CODE(S)

Examination included in the E/M — not separately reportable. Planned surgical: 58952 resection of ovarian malignancy with total abdominal hysterectomy, bilateral salpingo-oophorectomy, and omentectomy with radical debulking; 38770 pelvic lymphadenectomy; 38780 retroperitoneal lymphadenectomy as indicated

CHEMOTHERAPY / INFUSION MANAGEMENT CODE(S)

Not applicable this visit — no infusion given. Planned: 96413 / 96415 for cycles 5 and 6

SURGICAL PLANNING CODE(S)

Bundled in the time-based E/M; pre-operative clearance coordination documented

CARE COORDINATION / GENETIC COUNSELING CODE(S)

Genetic counselling billed separately by the genetics service; coordination bundled here

BASIS FOR BILLING

Time-based (84 minutes) with high-complexity MDM — restaging interpretation, surgical decision-making, chemotherapy modification for grade 2 toxicity, and germline result management with cascade implications

PRIMARY DIAGNOSIS

C56.9 — Malignant neoplasm of unspecified ovary (high-grade serous carcinoma, FIGO stage IIIC)

SECONDARY DIAGNOSES

C78.6 Secondary malignant neoplasm of retroperitoneum and peritoneum; Z51.12 Encounter for antineoplastic immunotherapy/chemotherapy; G62.0 Drug-induced polyneuropathy; Z15.01 Genetic susceptibility to malignant neoplasm of breast (BRCA1); Z80.41 Family history of malignant neoplasm of ovary; D64.9 Anemia, unspecified; E61.1 Iron deficiency; R29.6 Repeated falls; N95.2 Postmenopausal atrophic vaginitis; Z78.0 Asymptomatic menopausal state; Z95.828 Presence of vascular access port; I10 Essential hypertension; E03.9 Hypothyroidism; M85.80 Osteopenia

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Priyanka S. Deshmukh, MD	MD — Gynecologic Oncology	Gynecologic Oncology	08/20/2026	15:36

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