Case Discussion- Advanced Ovarian Cancer

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Joint BGS, Macmillan and RCR Meeting

Background

- 70 year old with high grade serous ovarian cancer
- Treated with surgery (required ileostomy) and 6 cycles of chemotherapy
- Recurrence 1 year later- restarted on chemotherapy
- After 3rd cycle of carboplatin- admitted with abdominal pain, reduced stoma output, nausea and vomiting

August

- CT- static disease but multi level small bowel obstruction due to peritoneal disease
- Treated with metoclopramide and morphine CSCI, NG tube and commenced TPN
- Changed to Cisplatin
- Ongoing symptoms, driver increased and changed

August- October

- Became more withdrawn, reduced PS, reduced mobility, poor engagement with others
- Psychiatry thought severe depression. Patient refused to take antidepressant
- Psychiatry thought patient lacked capacity for this decision

October-November

- Interval CT: Reduced nodal disease, static peritoneal disease and ongoing small bowel obstruction
- Overall given poor clinical improvement, decided cisplatin ineffective
- Long discussions over about 10 days with patient and her family about trying further chemotherapy
- Overall wanted to proceed and we thought she had capacity to decide this

October-November

- Switched to weekly paclitaxel
- Ongoing poor engagement, now also noted to have a “mask like” expression and bradykinesia
- Difficult decision for anti-emetics- changed back to levomepromazine
- Vomiting initially worsened

November- December

- Slowly improved. By mid November NG out and weaned off TPN. CT -resolution of SBO
- Transferred to rehabilitation ward and attended for chemo as “an outpatient” whilst on rehabilitation ward
- Discharged 24/12/18
- Currently- progressive disease start of February. No further chemotherapy options planned.

Interesting discussion points

- Capacity to consent for chemo vs. anti-depressant
- Choices of anti-emetics with likely drug induced parkinsonism
- Should she have been move to rehabilitation?
- Should she had continued treatment?