

Home-Based Hospice Care in Recurrent FIGO Stage IIIC High-Grade Serous Ovarian Carcinoma: A Three-Year Case Report From Cytoreductive Surgery to End-of-Life Care in India

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Abstract

Background: Stage IIIC high-grade serous ovarian carcinoma (HGSOC) is commonly diagnosed with extensive peritoneal dissemination and is characterized by a high risk of recurrence despite optimal cytoreductive surgery and platinum-based chemotherapy. In low- and middle-income countries (LMICs), limited access to hospice and specialist palliative care often results in burdensome, low-value interventions during the terminal phase of illness.

Case Presentation: A 44-year-old woman presented with progressive abdominal distension and pain and was diagnosed with FIGO Stage IIIC HGSOC based on contrast-enhanced computed tomography (CT), 18F-fluorodeoxyglucose positron emission tomography/computed tomography (18F-FDG PET/CT), and histopathological examination. She underwent optimal primary cytoreductive surgery followed by six cycles of carboplatin–paclitaxel chemotherapy and maintenance therapy, achieving a disease-free interval of approximately 12 months. Six months after completion of maintenance treatment, she developed recurrent peritoneal and omental disease. Despite multiple subsequent lines of systemic chemotherapy and a second palliative abdominal operation, the disease progressed to diffuse peritoneal carcinomatosis, malignant bowel obstruction, and severe cancer-associated cachexia. During the terminal stage, her functional status deteriorated to an Eastern Cooperative Oncology Group (ECOG) performance status of 4, with loss of both oral intake and reliable intravenous access, rendering further anticancer treatment clinically inappropriate. Following multidisciplinary discussions and shared decision-making with the patient’s family, goals of care were redirected from life-prolonging treatment to comfort-focused management. She was enrolled in a district home-based hospice program, where symptoms were effectively controlled using subcutaneous morphine, antiemetics, and anxiolytic medications. Consistent with evidence-based end-of-life care principles, artificial nutrition and hydration, feeding tubes, and tracheostomy were not initiated. The patient died peacefully at home, surrounded by her family, approximately three years after her initial diagnosis. **Conclusion:** This case illustrates the clinical trajectory of advanced HGSOC with recurrent peritoneal carcinomatosis and highlights the value of early palliative care integration and timely hospice referral. Home-based hospice care enabled effective symptom control, avoided non-beneficial invasive interventions, and supported a dignified end-of-life experience within a resource-constrained healthcare setting.

Keywords: High-grade serous ovarian carcinoma; FIGO Stage IIIC; Peritoneal carcinomatosis; Home-based hospice

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1. Introduction

Ovarian cancer remains one of the most lethal gynecologic malignancies worldwide because it is frequently diagnosed at an advanced stage. In India, it is the third most common gynecologic cancer and a leading cause of gynecologic cancer-related mortality, with more

than 47,000 new cases and approximately 32,000 deaths reported annually. The disease is often referred to as a “silent killer” because its early symptoms including abdominal bloating, pelvic discomfort, and early satiety are vague and nonspecific, resulting in delayed diagnosis.

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Consequently, nearly two-thirds of patients present with International Federation of Gynecology and Obstetrics (FIGO) Stage III or IV disease, by which time extensive peritoneal dissemination and omental involvement are frequently present. Advanced-stage disease is therefore associated with a poor prognosis despite significant advances in surgical and systemic therapies.

FIGO Stage IIIC high-grade serous ovarian carcinoma (HGSOC) is characterized by macroscopic peritoneal metastases beyond the pelvis measuring more than 2 cm and/or regional lymph node involvement without distant parenchymal metastases. Current standard treatment consists of maximal cytoreductive surgery aimed at achieving no gross residual disease, followed by platinum-taxane chemotherapy with or without maintenance therapy according to tumor biology and treatment response. Although optimal cytoreduction substantially improves survival, recurrence remains common, with approximately 70–80% of patients ultimately developing recurrent disease, most frequently within the peritoneal cavity. Five-year overall survival for Stage IIIC disease remains approximately 25–35%, underscoring the aggressive biological behavior of advanced HGSOC.

Peritoneal carcinomatosis produces a distinctive constellation of symptoms that substantially impairs quality of life. Progressive omental disease, mesenteric involvement, and diffuse serosal metastases frequently result in abdominal pain, ascites, nausea, vomiting, malignant bowel obstruction, cachexia, and severe nutritional decline. These physical manifestations are often accompanied by psychological distress, caregiver burden, loss of independence, and existential suffering, together constituting the multidimensional concept of “total pain.” As the disease progresses, repeated systemic therapies generally provide diminishing clinical benefit while treatment-related toxicity increases, necessitating a gradual transition from disease-directed therapy to symptom-focused care.

The World Health Organization (WHO) defines palliative care as an approach that improves the quality of life of patients and their families through the prevention and relief of suffering by early identification, comprehensive assessment, and management of physical, psychosocial, and spiritual problems. Hospice care represents a specialized component of palliative care that is appropriate when life expectancy is limited and treatment goals have shifted entirely toward comfort rather than prolongation of life. International oncology guidelines now recommend early integration of palliative care for patients with advanced ovarian cancer because it improves symptom control, quality of life, communication regarding goals of care, and patient and caregiver satisfaction while reducing unnecessary hospitalizations and aggressive end-of-life interventions [1–3].

Despite these recommendations, access to specialist palliative and hospice services remains limited across many low- and middle-income countries, including India. Although millions of individuals require palliative care annually, only a small proportion receive comprehensive services. Barriers include inadequate workforce capacity,

limited clinician training, insufficient public awareness, restricted access to essential opioids despite regulatory reforms, and persistent misconceptions that palliative care signifies abandonment of active treatment. National initiatives such as the National Programme for Palliative Care (NPPC) and state-level policies have sought to expand access by integrating palliative services into district hospitals and primary healthcare systems; however, implementation remains heterogeneous across regions.

Determining the appropriate timing for transition from active oncologic treatment to hospice care represents one of the most challenging aspects of advanced cancer management. Clinical indicators supporting this transition include deterioration to Eastern Cooperative Oncology Group (ECOG) performance status 3 or 4, progressive disease despite multiple lines of evidence-based therapy, refractory symptoms, malignant bowel obstruction, inability to maintain adequate oral intake, and loss of reliable enteral or intravenous routes for nutrition and medication administration. Under these circumstances, additional anticancer treatment rarely provides meaningful benefit and may instead increase patient suffering.

Decision-making during the terminal phase is further complicated by consideration of invasive interventions such as artificial nutrition and hydration, feeding tube placement, repeated hospital admissions, intensive care unit transfer, or tracheostomy. Available evidence indicates that these interventions seldom improve survival or quality of life in patients with advanced peritoneal carcinomatosis and limited life expectancy and may instead increase procedural complications, symptom burden, and healthcare utilization. Conversely, timely hospice referral has consistently been associated with improved symptom management, greater concordance between care and patient preferences, reduced use of non-beneficial medical interventions, improved caregiver outcomes, and a greater likelihood of dying peacefully at home [4–6].

Community-based palliative care models, particularly those pioneered in Kerala, have demonstrated that multidisciplinary home-based hospice services can provide effective symptom control, psychosocial support, and caregiver education while remaining both feasible and cost-effective in resource-constrained settings. However, similar models remain underdeveloped in many regions of India, including Telangana, highlighting the need for additional evidence illustrating their implementation in patients with advanced gynecologic malignancies.

Case reports provide valuable clinical insight into complex transitions from active cancer treatment to end-of-life care, particularly in settings where hospice services are still evolving. They illustrate not only disease progression but also the ethical, clinical, and psychosocial considerations underlying decisions to discontinue disease-directed therapy and prioritize comfort-focused care. The present case describes the three-year clinical course of a 44-year-old woman with FIGO Stage IIIC HGSOC, from optimal cytoreductive surgery and initial remission to recurrent peritoneal carcinomatosis, progressive functional decline, and peaceful death under

home-based hospice care in Telangana, India. This report highlights the importance of timely palliative care integration, multidisciplinary shared decision-making, and avoidance of non-beneficial invasive interventions during the final stage of life, while emphasizing the role of home-based hospice care in delivering dignified, patient-centered end-of-life care within a resource-limited healthcare system.

2. Case Presentation

A 44-year-old woman with no significant medical comorbidities presented in February 2023 with progressive abdominal distension, dull abdominal pain, and early satiety that had developed over several weeks. She denied vaginal bleeding and significant weight loss but reported increasing abdominal discomfort that interfered with her daily activities. Physical examination demonstrated abdominal distension with shifting dullness, consistent with ascites, and fullness in the left adnexal region. No palpable lymphadenopathy or clinical evidence of distant metastatic disease was identified.

2.1 Initial Imaging and Staging

Contrast-enhanced computed tomography (CECT) of the abdomen and pelvis, performed on 1 February 2023, demonstrated diffuse omental thickening with omental caking measuring up to 3.5 cm, exhibiting heterogeneous contrast enhancement, together with multiple enhancing soft-tissue nodules throughout the omentum. Multiple enhancing mesenteric nodules were present along the mesenteric vessels, with obliteration of the fat planes between peritoneal deposits and adjacent bowel loops, suggesting serosal involvement. A small subcapsular lesion over the bare area of the liver, interpreted as either a surface deposit or an organized fluid collection, and several enlarged diaphragmatic lymph nodes were also identified. The left ovary was enlarged (56 × 42 mm) with heterogeneous enhancement, whereas the uterus and right ovary appeared unremarkable. No significant retroperitoneal or pelvic lymphadenopathy or distant visceral metastases were detected. These findings were highly suggestive of advanced epithelial ovarian carcinoma with extensive peritoneal carcinomatosis.

To further evaluate disease extent, whole-body 18F-FDG PET/CT was performed on 5 February 2023. The examination demonstrated intense FDG uptake within the left ovarian mass (SUV_{max} 12.3), consistent with a metabolically active primary ovarian malignancy. Diffuse FDG-avid omental caking (SUV_{max} 9.8) and multiple hypermetabolic nodules involving the omentum, mesentery, and pelvic peritoneum confirmed extensive peritoneal dissemination. Additional FDG uptake was observed in diaphragmatic lymph nodes (SUV_{max} 6.1) and the subcapsular hepatic surface lesion. No abnormal uptake was identified within the liver parenchyma, lungs, bones, or extra-abdominal lymph nodes, excluding distant metastatic disease. The imaging findings were consistent with FIGO Stage IIIC disease. Serum CA-125 was markedly elevated (exact value unavailable in the source records), further supporting the diagnosis of advanced

epithelial ovarian carcinoma. Considering the imaging findings and the patient's good performance status, primary cytoreductive surgery was planned in accordance with contemporary treatment guidelines.

2.2 Primary Cytoreductive Surgery and Histopathological Findings

On 15 February 2023, the patient underwent diagnostic laparoscopy followed by conversion to laparotomy for primary cytoreductive surgery. Approximately 1.2 L of straw-colored ascitic fluid was evacuated. Intraoperative examination revealed diffuse tumor deposits involving the omentum, pelvic peritoneum, and diaphragmatic surfaces, together with a 6-cm left ovarian mass adherent to the sigmoid colon. Optimal cytoreduction was achieved through bilateral salpingo-oophorectomy, infracolic omentectomy, and resection of all visible peritoneal implants, leaving residual disease measuring less than 1 cm. No gross liver parenchymal or extra-abdominal metastases were observed.

Histopathological examination of the ovarian tumor, omentum, and peritoneal biopsy specimens confirmed high-grade serous carcinoma characterized by marked nuclear pleomorphism, frequent mitotic figures, and occasional psammoma bodies. Immunohistochemistry demonstrated positivity for WT1 and PAX8, aberrant (mutant-type) p53 expression, and estrogen receptor positivity, confirming the diagnosis of high-grade serous epithelial ovarian carcinoma. Cytological analysis of the ascitic fluid was positive for malignant epithelial cells. Based on the presence of peritoneal implants extending beyond the pelvis (>2 cm), diaphragmatic lymph node involvement, and the absence of distant visceral metastases, the disease was classified as FIGO Stage IIIC.

2.3 Adjuvant Chemotherapy and Remission

Following optimal cytoreductive surgery, the patient received six cycles of adjuvant carboplatin–paclitaxel chemotherapy in accordance with standard treatment guidelines for FIGO Stage IIIC high-grade serous ovarian carcinoma. Given the advanced stage and extensive peritoneal disease, maintenance therapy was subsequently initiated to prolong progression-free survival, although the specific agent and treatment schedule were not available in the source records. Treatment was generally well tolerated, with only expected chemotherapy-related toxicities and no serious adverse events requiring discontinuation. Post-treatment evaluation demonstrated complete clinical remission, with normalization of serum CA-125 levels and no radiological evidence of residual or recurrent disease. The patient resumed her usual daily activities and remained clinically well for approximately 12 months, a disease-free interval consistent with the expected outcomes reported for optimally debulked Stage IIIC ovarian cancer treated with platinum-based chemotherapy.

2.4 Disease Recurrence and Progression

Approximately 12 months after achieving remission, the patient developed recurrent abdominal pain, early satiety, and intermittent abdominal bloating. Repeat

imaging demonstrated recurrent peritoneal disease with omental involvement and multiple peritoneal nodules, consistent with peritoneal carcinomatosis. During the subsequent eight months, she underwent several additional lines of systemic chemotherapy, although details of these regimens were unavailable, and later underwent a second abdominal operation aimed at palliation of obstructive symptoms. Despite these interventions, the disease continued to progress, with diffuse intraperitoneal dissemination.

As the disease advanced, the patient developed progressive abdominal distension, recurrent vomiting consistent with malignant bowel obstruction, profound weight loss, and cancer-related cachexia. Her functional status steadily deteriorated from an ECOG performance status of 1–2 during remission to ECOG 4 in the terminal stage. She became completely bedbound, dependent on caregivers for all activities of daily living, and unable to attend outpatient visits without extensive assistance. Repeated venous cannulations resulted in poor peripheral venous access, making intravenous treatment increasingly difficult. Progressive dysphagia eventually prevented oral intake, including medications, while reliable intravenous administration also became impractical. In light of her advanced disease, poor performance status, and the absence of meaningful therapeutic options, the multidisciplinary oncology team concluded that further disease-directed treatment would be non-beneficial and would only increase the patient's burden.

2.5. Transition to Hospice and Home-Based Palliative Care

Following recognition of progressive, treatment-refractory disease, a multidisciplinary family conference involving the oncology team, palliative care physician, nursing staff, the patient, and her family was conducted to review the goals of care. After discussing the expected disease trajectory and the limited benefits of further chemotherapy or invasive interventions, including feeding tubes, parenteral nutrition, and tracheostomy, a shared decision was reached to transition from disease-directed treatment to comfort-focused care. The patient and her family expressed a clear preference for remaining at home during the final stage of life.

She was subsequently enrolled in a district home-based palliative care program operating within the framework of India's National Programme for Palliative Care. Symptom management focused on maintaining comfort and quality of life. Pain and dyspnea were effectively controlled with subcutaneous morphine, while nausea and vomiting were managed using haloperidol and other antiemetic agents. Antisecretory medications were administered to relieve symptoms associated with malignant bowel obstruction, and anxiolytic medications, including midazolam when required, were available for episodes of agitation and anxiety.

Consistent with current palliative care guidelines, artificial hydration and nutritional support were not initiated because they were unlikely to improve either survival or patient comfort in the setting of

advanced peritoneal carcinomatosis. The hospice team provided regular home visits, telephone support, and education for family caregivers regarding medication administration, symptom monitoring, and basic nursing care. Psychological, emotional, and spiritual support was also offered to both the patient and her family throughout the terminal phase.

During her final weeks, the emphasis remained entirely on symptom relief and maintaining dignity. She required no further hospital admissions, emergency department visits, or invasive procedures. Approximately three years after her initial diagnosis, the patient died peacefully at home in the presence of her family. According to reports from both the hospice team and family members, she experienced good symptom control without evidence of severe pain or distress during her final days. Her end-of-life care reflected her stated preferences and illustrates the value of timely hospice referral and integrated home-based palliative care for patients with advanced ovarian cancer in resource-limited settings.

3. Treatment and Outcome

Following confirmation of FIGO Stage IIIC high-grade serous ovarian carcinoma, the patient underwent multimodal treatment with curative intent, consisting of primary cytoreductive surgery followed by platinum-based chemotherapy. At the time of diagnosis, the disease was confined to the peritoneal cavity, with diffuse omental caking, multiple mesenteric nodules, diaphragmatic involvement, and peritoneal implants, without evidence of distant parenchymal metastases. This distribution of disease made primary cytoreductive surgery the preferred initial treatment strategy.

Optimal cytoreductive surgery was performed in February 2023. Intraoperatively, approximately 1.2 L of ascitic fluid was evacuated, and extensive tumor deposits involving the omentum, pelvic peritoneum, and diaphragmatic surfaces were identified. A 6-cm left ovarian mass adherent to the sigmoid colon was resected, and optimal debulking was achieved with residual disease measuring less than 1 cm. Histopathological examination, supported by immunohistochemistry, confirmed high-grade serous ovarian carcinoma. Because the extent of residual disease after cytoreduction is one of the strongest prognostic factors in advanced ovarian cancer, achieving optimal debulking represented a favorable surgical outcome.

Following recovery from surgery, the patient completed six cycles of adjuvant carboplatin–paclitaxel chemotherapy, the current standard first-line regimen for advanced epithelial ovarian cancer. Owing to the advanced stage and high risk of recurrence, maintenance therapy was subsequently initiated, although details of the specific agent were unavailable. Treatment was well tolerated, allowing completion of the planned regimen. Post-treatment assessment demonstrated complete clinical remission, normalization of serum CA-125 levels, and no radiological evidence of residual disease. The patient resumed her normal daily activities and remained disease-free for approximately 12 months.

Despite this favorable initial response, disease recurrence occurred approximately one year later. The patient presented with persistent abdominal pain, early satiety, and abdominal bloating, and imaging confirmed recurrent peritoneal carcinomatosis with omental involvement. This pattern of relapse is characteristic of high-grade serous ovarian carcinoma, in which the peritoneum is the predominant site of recurrence even after optimal primary treatment. Following recurrence, treatment goals shifted from curative intent to prolongation of disease control and symptom palliation. During the subsequent eight months, the patient received several additional lines of systemic chemotherapy and underwent a second abdominal operation to alleviate obstructive symptoms. Nevertheless, the disease continued to progress despite these interventions.

As the disease advanced, the patient experienced progressive abdominal distension, recurrent vomiting consistent with malignant bowel obstruction, profound cachexia, worsening frailty, and continuous deterioration in functional capacity. Her performance status declined to ECOG grade 4, leaving her completely bedbound and dependent on caregivers for all activities of daily living. Repeated venous cannulations resulted in loss of reliable peripheral venous access, while progressive dysphagia prevented oral intake of food, fluids, and medications. At this stage, the multidisciplinary oncology team concluded that further systemic therapy would provide no meaningful clinical benefit and would likely increase treatment-related burden. Accordingly, the goals of care were redefined through shared decision-making with the patient and her family, shifting from disease-directed therapy to symptom relief, comfort, and preservation of dignity.

The patient was subsequently referred to a home-based hospice program operated through a district palliative care service. Symptom management relied primarily on the subcutaneous route because oral and intravenous administration were no longer feasible. Subcutaneous morphine was administered for pain and dyspnea, while haloperidol and other antiemetics were used to control nausea and vomiting. Antisecretory agents were prescribed for symptoms related to malignant bowel obstruction, and midazolam was available for the management of anxiety and terminal agitation. Consistent with contemporary palliative care guidelines, artificial hydration, parenteral nutrition, feeding tube placement, and tracheostomy were not initiated because these interventions were unlikely to improve either survival or comfort during the terminal phase and could potentially increase patient suffering.

The hospice team provided regular home visits, telephone support, caregiver education, and psychosocial and spiritual counseling throughout the final weeks of life. No further hospital admissions, emergency department visits, or invasive procedures were required after hospice enrollment. Symptom control remained satisfactory, allowing the patient to remain at home in accordance with her wishes and those of her family.

Approximately three years after the initial diagnosis, the patient died peacefully at home surrounded by her family. Her final phase of care emphasized comfort,

dignity, and relief of suffering rather than non-beneficial life-prolonging interventions. Although the underlying malignancy remained incurable, timely integration of hospice services enabled effective symptom control, avoided unnecessary invasive procedures, and ensured that end-of-life care aligned with the patient's preferences. This case illustrates both the aggressive natural history of recurrent FIGO Stage IIIC high-grade serous ovarian carcinoma and the important role of early palliative integration and home-based hospice care in achieving high-quality, patient-centered end-of-life care in resource-limited settings.

4. Discussion

This case illustrates the clinical course of advanced FIGO Stage IIIC high-grade serous ovarian carcinoma despite treatment according to current standards of care. Following optimal primary cytoreductive surgery and six cycles of platinum-based chemotherapy with maintenance therapy, the patient achieved complete clinical remission and remained disease-free for approximately one year. Nevertheless, recurrence occurred within the peritoneal cavity and was followed by progressive clinical deterioration despite multiple subsequent therapeutic interventions. This trajectory reflects the aggressive biological behavior of high-grade serous ovarian carcinoma, which remains one of the most lethal gynecologic malignancies worldwide. Despite advances in surgery, systemic therapy, and maintenance strategies, many patients with advanced epithelial ovarian cancer experience relapse after an initial response, contributing to persistent mortality associated with this disease [7, 8]. High-grade serous carcinoma particularly demonstrates a strong tendency for diffuse peritoneal dissemination, which frequently determines both disease progression and symptom burden [9].

A prominent feature of this case was the central role of peritoneal carcinomatosis in determining both therapeutic limitations and quality of life. Progressive intraperitoneal disease resulted in abdominal pain, recurrent malignant bowel obstruction, persistent nausea and vomiting, severe cachexia, dysphagia, and eventual loss of both oral and intravenous routes for medication administration. These manifestations represent common consequences of advanced ovarian cancer recurrence and are associated with substantial physical and psychological distress. Malignant bowel obstruction is a particularly challenging complication in recurrent ovarian cancer, often indicating advanced disease, limited treatment options, and poor prognosis [10, 11]. Although selected patients may benefit from interventions such as decompressive procedures or home parenteral nutrition, evidence regarding meaningful improvement in survival or quality of life remains limited, particularly among patients with poor performance status and extensive carcinomatosis [12].

An important aspect of this case was the timely recognition of the transition point from disease-directed treatment to comfort-focused care. In clinical practice, referral to palliative or hospice care is frequently delayed because of unrealistic expectations regarding additional

chemotherapy, difficulty communicating prognosis, or the misconception that palliative care represents abandonment of active treatment. In this patient, however, the combination of ECOG performance status 4, profound cachexia, inability to tolerate oral medications, malignant bowel obstruction, and loss of reliable intravenous access clearly indicated that further anticancer therapy was unlikely to provide meaningful benefit. The decision to redirect treatment goals toward symptom control and quality of life was therefore clinically appropriate and consistent with ethical principles of proportionality, beneficence, and respect for patient autonomy [13].

The hospice phase further demonstrates the effectiveness of evidence-based symptom management during advanced cancer. When conventional routes of drug administration were no longer feasible, subcutaneous medications provided reliable control of pain, dyspnea, nausea, and terminal agitation while minimizing patient discomfort. Equally important was the decision to avoid invasive interventions, including artificial nutrition, hydration, feeding tube placement, and tracheostomy. Current evidence suggests that routine artificial hydration or nutritional support in patients with advanced cancer and limited life expectancy does not consistently improve survival, comfort, or quality of life and should therefore be individualized according to patient goals and clinical circumstances [14]. Appropriate limitation of non-beneficial interventions represents an essential component of high-quality end-of-life care, particularly in patients with progressive malignant bowel obstruction and severe functional decline [13, 14].

This case also highlights the importance of home-based hospice care in resource-limited settings such as India. Although access to specialist palliative care remains limited in many regions, the patient's successful management through a district palliative care service demonstrates that high-quality end-of-life care can be delivered outside the hospital when multidisciplinary support systems are available. Community-based palliative care models, particularly those developed in Kerala, have demonstrated the feasibility of providing symptom control, caregiver education, psychosocial support, and compassionate care through decentralized healthcare structures [15, 16]. Such approaches may represent practical and scalable models for improving access to palliative care in other resource-constrained regions.

Beyond survival outcomes, this case emphasizes that quality of care during the terminal phase should be considered an important measure of treatment success. Although the patient survived approximately three years after diagnosis, the most meaningful outcomes during the final phase were effective symptom control, preservation of dignity, avoidance of unnecessary invasive procedures, and death in her preferred environment. Contemporary evaluations of end-of-life cancer care increasingly emphasize indicators such as appropriate hospice utilization, reduction of potentially burdensome interventions, effective communication regarding goals of care, and concordance between treatment decisions and

patient preferences [17]. Early and honest discussions regarding prognosis and future care preferences can facilitate shared decision-making, reduce unnecessary aggressive interventions near the end of life, and improve outcomes for both patients and caregivers [18].

Finally, this report reinforces the importance of integrating palliative care early in the management of advanced ovarian cancer. Early palliative involvement allows systematic symptom assessment, advance care planning, caregiver support, and improved communication throughout the disease trajectory. Rather than being considered an alternative to anticancer therapy, hospice and palliative care should be viewed as integral components of comprehensive oncology care. For patients with advanced recurrent ovarian cancer, timely transition to comfort-focused care can ensure that treatment remains aligned with individual values, clinical realities, and the goal of minimizing suffering while preserving dignity.

Patient Consent

Written informed consent for publication of this anonymized case report was obtained from the patient's next of kin.

Conflict of Interest

The author declares no competing financial or personal interests related to this work.

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