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Severe Chemotherapy-Induced Peripheral Neuropathy In Ovarian Cancer: A Case-Based Approach To Dose Modification And Supportive Care.

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Abstract

Background : Chemotherapy-induced peripheral neuropathy (CIPN) constitutes a frequently occurring side effect which restricts treatment limits for taxane-based chemotherapy particularly paclitaxel which doctors use to treat ovarian cancer. The condition mainly targets sensory nerves which cause patients to experience symptoms including tingling and numbness and burning pain that spreads through their body in a symmetrical pattern resembling stocking and glove distribution. CIPN creates life challenges which require patients to reduce their chemotherapy doses or stop treatment entirely. Doctors need to identify patients early and provide proper treatment because this process helps them avoid developing permanent neurological damage while maintaining their effective cancer treatment.

Case Presentation : A 58-year-old female with stage IIIC ovarian cancer developed progressive neuropathic symptoms after receiving multiple cycles of paclitaxel and carboplatin chemotherapy. She experienced intense tingling and numbness and burning pain which together caused her to lose her capability to move normally throughout her everyday tasks. The neurological examination showed that patients had reduced ability to feel in their body parts while they exhibited decreased ankle reflexes. The laboratory tests confirmed the absence of metabolic disorders. The patient treatment required stopping paclitaxel which was followed by complete treatment cessation and doctors started dulcextine and vitamin therapy and physiotherapy. The patient demonstrated progress in her condition during the six-week period.

Conclusion : This case demonstrates that doctors need to identify CIPN patients early and start treatment without delay. The combination of dose adjustment and elimination of the problematic medication together with medical assistance results in decreased patient symptoms and better patient outcomes. Doctors need to create personalized treatment plans which enable them to achieve treatment success while managing toxic effects so patients can have better lives.

Keywords: Chemotherapy-induced peripheral neuropathy, ovarian cancer, paclitaxel, duloxetine, dose modification, supportive care

Introduction

Ovarian cancer stands as one of the deadliest gynecological cancers which causes continuous death rates among women throughout the globe. The disease enters advanced stages because it lacks definite early warning signs thus creating difficulties for medical professionals to provide treatment. Standard management includes cytoreductive surgery followed by combination chemotherapy which usually involves paclitaxel and carboplatin as the most common drug combination.[1] The treatment regimen has improved survival rates because of its beneficial effects on patients, but it also leads to multiple harmful effects. The toxicities present in the treatment will81 create problems which make patients stick to their treatment schedule. These issues will87 result in therapy delays, which will87 force doctors to reduce medication, and this will89 lead to negative effects on both clinical results and patient wellbeing throughout their extended cancer therapy.[2]

Chemotherapy-induced peripheral neuropathy (CIPN) stands as the main adverse effect which occurs in patients who receive anticancer treatment especially those who use taxanes such as paclitaxel. CIPN primarily affects sensory nerves and typically presents as tingling, numbness, burning pain, or altered sensations in a symmetrical "stocking–glove" distribution involving hands and feet.[3] Severe cases of the disease will result in both sensory and motor nerves becoming affected which causes patients to experience weakness and coordination difficulties. The symptoms of these conditions will91 develop in severity while they will91 disrupt daily tasks which include walking and writing and holding objects. The patient will experience a drop in both physical capacity and mental health during their treatment period.[4]

The progression of CIPN symptoms develops through two factors which include chemotherapy treatment dosage and total treatment duration. Patients and doctors often miss the first symptoms because they appear only as minor complaints

which lead to treatment delays. The condition of neuropathy will advance to its most severe stage when doctors do not treat it with proper methods. The existing preventive methods show limited success because current treatments only target patient symptoms[5].

The report presents complete clinical details about a patient who developed severe CIPN while undergoing paclitaxel-based chemotherapy for ovarian cancer. The case study demonstrates how doctors should notice neuropathic symptoms which need to undergo proper neurological assessment because they require both pharmacological treatment and physical therapy. The case demonstrates that doctors need to create personalized treatment plans which require patients to either change their drug dosage or stop taking their current medications because it helps them achieve treatment goals while managing their side effects.[6,7]

Case Presentation

Patient Demographics

A 58-year-old female, weighing 62 kg, with a height of 158 cm (BMI: 24.8 kg/m²), presented to the oncology department. She is a resident of a semi-urban area in Andhra Pradesh, India. The patient is married, lives with her family, and is moderately active in daily life.

Chief Complaints

- Progressive numbness and tingling in both feet and hands – 6 weeks
- Burning sensation in lower limbs – 4 weeks
- Difficulty in walking and imbalance – 3 weeks
- Weakness in grip strength – 2 weeks

History of Present Illness

The patient was diagnosed with stage IIIC epithelial ovarian carcinoma 5 months prior and underwent optimal cytoreductive surgery followed by adjuvant chemotherapy with paclitaxel and carboplatin. After the third chemotherapy cycle, she noticed mild tingling in her toes, which was intermittent and did not interfere with daily activities (Grade 1 neuropathy). Despite reporting symptoms, chemotherapy was continued without dose adjustment.Following the fifth cycle, symptoms progressed significantly, becoming continuous and more intense. The patient experienced:

- Ascending numbness from feet to knees
- Involvement of hands with reduced tactile sensation
- Severe burning pain, particularly at night
- Difficulty in buttoning clothes and holding objects
- Gait instability requiring support

Symptoms were not associated with bowel/bladder dysfunction or cranial nerve involvement.

Past Medical History

- No history of diabetes mellitus
- No hypertension
- No thyroid disorders
- No prior neurological illness
- No history of alcohol-related neuropathy

Medication History

Oncology Treatment:

- Paclitaxel 175 mg/m² IV infusion every 3 weeks
- Carboplatin (AUC 5) IV every 3 weeks
- Total cycles received: 5

Supportive Medications During Chemotherapy:

- Ondansetron for nausea
- Dexamethasone as premedication
- Proton pump inhibitors (pantoprazole)

Family History

- No family history of malignancy
- No hereditary neurological disorders reported

Social History

- Non-smoker
- Non-alcoholic
- Diet: Mixed (vegetarian and non-vegetarian)
- No exposure to toxins or heavy metals
- Lives in a supportive family environment

Occupational History

The patient is a homemaker with no occupational exposure to neurotoxic substances such as chemicals, pesticides, or heavy metals.

Allergy History

- No known drug allergies
- No history of food or environmental allergies

General Physical Examination

- Conscious, oriented, cooperative
- Vital signs stable:
  - Blood Pressure: 124/78 mmHg
  - Heart Rate: 82 bpm
  - Respiratory Rate: 16/min
  - Temperature: Afebrile

Neuropathy Evaluation

Nerve Conduction Study (NCS)

Nerve Tested	Parameter	Patient Value	Normal Range	Interpretation
Sural Nerve (Sensory, Lower Limb)	SNAP Amplitude	4.2 µV	>10 µV	Reduced
	Conduction Velocity	37 m/s	>45 m/s	Slowed
Median Nerve (Sensory, Upper Limb)	SNAP Amplitude	7.8 µV	>15 µV	Reduced
	Conduction Velocity	41 m/s	>50 m/s	Slowed
Peroneal Nerve (Motor, Lower Limb)	CMAP Amplitude	6.3 mV	>5 mV	Normal
	Conduction Velocity	47 m/s	>45 m/s	Normal
Median Nerve (Motor, Upper Limb)	CMAP Amplitude	5.6 mV	>5 mV	Normal
	Conduction Velocity	50 m/s	>50 m/s	Normal

Findings are suggestive of **sensory-predominant axonal peripheral neuropathy** with preserved motor nerve function, consistent with chemotherapy-induced neurotoxicity.

Total Neuropathy Score (TNS)

Component	Patient Finding	Score (0–4)
Sensory Symptoms	Tingling, numbness in hands and feet	2
Motor Symptoms	Mild distal weakness (intermittent)	1
Autonomic Symptoms	Absent	0
Pin Sensation	Decreased in stocking–glove pattern	2
Vibration Sense	Reduced at toes and ankles	1
Strength	Slightly reduced distally	1
Reflexes	Ankle reflexes reduced	1

Total Score = 8/28 → Moderate Neuropathy

Clinical Interpretation

- Pattern: Distal symmetrical polyneuropathy
- Type: Sensory predominant, axonal
- Severity: Moderate neuropathy (TNS), Grade 3 (CTCAE)
- Likely Cause: Cumulative neurotoxicity due to paclitaxel

Laboratory Investigations

Parameter	Patient Value	Normal Range	Interpretation
Hemoglobin	11.2 g/dL	12–15 g/dL	Mildly reduced
Total Leukocyte Count	6,800 cells/mm³	4,000–11,000	Normal
Platelet Count	2.5 lakh/mm³	1.5–4 lakh	Normal
Serum Creatinine	0.9 mg/dL	0.6–1.2 mg/dL	Normal
Blood Urea	24 mg/dL	7–20 mg/dL	Slightly elevated
Fasting Blood Glucose	96 mg/dL	70–110 mg/dL	Normal
HbA1c	5.4%	<5.7%	Normal
Vitamin B12	420 pg/mL	200–900 pg/mL	Normal
Thyroid Stimulating Hormone (TSH)	2.1 µIU/mL	0.4–4.0 µIU/mL	Normal
Serum Electrolytes (Na^+/K^+)	Within normal limits	—	Normal

Causality assessment :

Causality assessment using the Naranjo scale yielded a score of 9, indicating a definite adverse drug reaction. The WHO-UMC criteria categorized the reaction as probable. The temporal relationship, improvement after dose modification, and absence of alternative causes strongly suggest that paclitaxel-induced chemotherapy was responsible for the peripheral neuropathy.

Final Diagnosis

The diagnosis of severe chemotherapy-induced peripheral neuropathy (CIPN) was established through clinical presentation, neurological examination, laboratory investigations, and nerve conduction studies testing results. The patient developed progressive symptoms which included symmetrical stocking–glove distribution numbness and tingling and burning pain and gait instability. The diagnosis was established through neurological findings of reduced distal sensation and diminished ankle reflexes and mild distal weakness which matched NCS results showing sensory axonal neuropathy. The laboratory results showed normal ranges which ruled out all metabolic disorders. The condition was classified as Grade 3 neuropathy because it caused major disruptions to daily life which needed both chemotherapy adjustment and additional medical treatment.

Treatment Details

Day 1 : The patient experienced increasingly severe tingling and numbness and burning feelings which affected both his upper and lower body movements as well as his ability to sleep. The patient experienced pain which is 7 out of 10 according to the Visual Analog Scale (VAS). The neurological assessment showed that the patient had lost the ability to feel vibrations and pinprick sensations in a symmetrical pattern which covered his entire body. The patient showed decreasing strength in his muscles which affected his distal body parts. The laboratory tests, which included blood glucose levels and vitamin B12 levels and thyroid function tests, showed normal results thus eliminating metabolic factors as possible causes. The nerve conduction studies showed that sensory nerve action potentials were decreased while the conduction speeds were slowed down which matched the diagnosis of sensory-predominant axonal neuropathy. The medical team decided to stop administering paclitaxel because the patient's condition reached grade three according to the severity assessment, while they established supportive treatment as his primary medical plan.

Day 2 : The medical team began administering pharmacological support to help treat the patient's neuropathic symptoms. The patient received a prescription for duloxetine 30 mg to take one time per day through mouth in order to treat his neuropathic pain and sleep problems. The doctor prescribed vitamin B-complex and methylcobalamin to the patient in order to assist with his nerve repair process and improve his nerve functioning. The patient received detailed counseling about foot protection methods, which included information about protective footwear and trauma avoidance. The patient received medication adherence training which included instructions about when to report any symptoms that became worse. The patient showed minimal sleep improvement together with reduced pain. The monitoring period showed no signs of drug side effects while the patient's vital signs stayed constant throughout the entire period.

Day 3: On Day 3, the patient continued to experience neuropathic symptoms, although a slight reduction in burning pain was noted. Tingling and numbness persisted, particularly in the lower limbs. Duloxetine therapy was continued without dose adjustment. Paracetamol was advised on an as-needed basis for additional pain relief. Physiotherapy was initiated, including balance training, coordination exercises, and gait stabilization techniques to improve mobility and reduce fall risk. The patient tolerated the treatment well, with no sedation or systemic adverse effects. Neurological examination showed no progression of deficits, and the overall condition remained stable with mild symptomatic relief.

Day 4: By Day 4, the patient reported partial improvement in symptoms, with pain intensity decreasing to 5/10 (VAS). Sensory disturbances persisted but were not worsening. Neurological findings remained stable, with no additional motor involvement. Duloxetine and vitamin supplementation were continued as per the existing regimen. The patient was advised to maintain a daily symptom diary documenting pain levels, sleep quality, and functional ability. Routine monitoring of vital signs and laboratory parameters showed no abnormalities. The clinical team recommended continuation of the current treatment plan with close observation, emphasizing early detection of any further progression of neuropathy.

Day 5–7 : During this period, the patient showed gradual stabilization of symptoms. Pain intensity reduced from 7/10 to 4/10, with noticeable improvement in sleep and overall comfort. Sensory deficits persisted but remained non-progressive. The patient reported improved confidence in walking and reduced fatigue during daily activities. Physiotherapy sessions were continued regularly, contributing to better balance and coordination. Duloxetine and vitamin supplementation were well tolerated, with no adverse effects reported. Laboratory parameters remained stable. Overall, clinical improvement indicated effective symptom control and stabilization of neuropathy, leading to enhanced quality of life and functional independence.

Week 2 : Following multidisciplinary evaluation, chemotherapy was cautiously resumed with a 25% reduction in paclitaxel dose, while carboplatin was continued unchanged. Supportive therapy with duloxetine and vitamin supplementation was maintained. The patient's pain remained stable at 4/10 (VAS), with no worsening of neurological symptoms. Regular neurological assessments were planned to monitor progression. The patient tolerated the modified chemotherapy regimen without any systemic complications. Emphasis was placed on early reporting of symptom changes. The treatment approach aimed to balance effective cancer therapy while minimizing further neurotoxicity and preserving the patient's functional status.

Week 3 : Despite dose reduction, neuropathic symptoms persisted and continued to affect daily functioning. Based on clinical assessment, paclitaxel was discontinued to prevent irreversible nerve damage. Carboplatin monotherapy was continued to maintain oncological treatment. Duloxetine dosage was increased to 60 mg once daily for improved pain control. Physiotherapy and supportive measures were continued. The patient reported gradual reduction in pain intensity and improved mobility. No new neurological deficits were observed. The decision to discontinue paclitaxel was considered appropriate in view of ongoing neurotoxicity and the need to prevent long-term complications.

Week 4: By Week 4, the patient showed noticeable clinical improvement. Pain intensity decreased to 3/10 (VAS), and sleep quality improved significantly. Sensory symptoms, although still present, were less severe and less frequent. Functional mobility improved, with better gait stability and increased independence in daily activities. Duloxetine 60 mg and vitamin supplementation were continued without modification. Physiotherapy sessions contributed to improved strength and coordination. No adverse effects were reported. The patient remained clinically stable, and the overall response to treatment was favorable, indicating effective management of chemotherapy-induced neuropathy.

Week 6 : At Week 6, significant recovery was observed. Pain reduced to 1–2/10 (VAS), and numbness markedly decreased. The patient regained near-normal functional ability, with improved gait and hand coordination. Neuropathy severity reduced to Grade 1, indicating mild residual symptoms. Duloxetine was continued with plans for gradual tapering based on clinical response. Physiotherapy was maintained to ensure continued improvement. The patient reported good quality of life and independence in daily activities. No further chemotherapy-related complications were observed, and the patient remained under regular follow-up for long-term monitoring and recovery assessment.

Outcome

Following timely dose modification and supportive management, the patient showed significant clinical improvement. Neuropathic pain gradually reduced from 7/10 to 1–2/10 on the Visual Analog Scale over six weeks. Sensory symptoms, including numbness and tingling, markedly decreased, and gait stability improved with physiotherapy. Functional independence was restored, allowing the patient to perform daily activities without assistance. Neuropathy severity improved from Grade 3 to Grade 1. Duloxetine was well tolerated and contributed to effective symptom control. Discontinuation of paclitaxel prevented further neurotoxicity, while continuation of carboplatin maintained oncological treatment. Overall, the patient experienced improved quality of life with no disease progression during follow-up.

Discussion

CIPN emerges as a widespread chemotherapy side effect which restricts treatment options for ovarian cancer patients undergoing paclitaxel-based chemotherapy. The condition primarily manifests through sensory neuropathy which affects the body in a symmetrical pattern that resembles a person wearing socks and gloves. The patient developed sensory symptoms which worsened across multiple chemotherapy treatments because he experienced cumulative neurotoxic effects. Park et al. observed similar results when they studied paclitaxel-induced

neuropathy which produces sensory axonal neuropathy at distal extremities in a dose-dependent manner. The research establishes a standard clinical progression which demonstrates how taxane treatment leads to peripheral nerve damage.[8]

Patients need to recognize neuropathy at an early stage because this condition requires continuous monitoring to stop permanent damage from occurring. The case shows that the patient progressed from mild to severe neuropathy because doctors did not treat his condition on time which matches what previous research has shown. The electrophysiological tests confirmed axonal damage through their detection of decreased sensory nerve action potentials, which matched Seretny et al.'s findings that identified sensory nerve damage as the main indicator of CIPN. The laboratory tests found no other causes for the condition, so chemotherapy emerged as the main reason for the symptoms. The study proves that complete assessments are necessary to identify CIPN cases.[9]

The management of CIPN presents difficulties because there are currently few drugs which have proven to be effective. The most effective treatment for painful CIPN according to research evidence is currently duloxetine. The research conducted by Smith et al. through their randomized clinical trial showed that duloxetine reduces neuropathic pain more effectively than a placebo treatment. The patient experienced significant pain relief and better sleeping patterns after clinicians first prescribed duloxetine and increased its dose. The patient achieved functional recovery through supportive treatments which included vitamin supplements and physiotherapy. The chemotherapy-induced neuropathy treatment requires a multimodal approach which current treatment guidelines support.[10]

The primary method for stopping further nerve injury involves changing or stopping the medication which causes the problem. The patient experienced major clinical improvements after he stopped taking paclitaxel although he continued taking carboplatin which provided effective cancer treatment. The method described has received endorsement from Hershman et al. who demonstrated that proper treatment balance requires clinicians to find equilibrium between beneficial treatment outcomes and toxic effect management. The patient experienced a neuropathy recovery from Grade 3 to Grade 1 within six weeks which demonstrates that CIPN can show partial recovery through timely treatment. The case study demonstrates the necessity for personalized treatment plans which involve cooperation between various medical experts.

Conclusion

The case demonstrates that severe chemotherapy-induced peripheral neuropathy (CIPN) acts as a major dose-limiting toxicity which affects the treatment of ovarian cancer through paclitaxel. Diagnostic accuracy requires medical professionals to identify symptoms at their initial stage and perform neurological evaluations while excluding potential alternative explanations. The patient achieved major clinical improvement through two actions which included immediate dose changes and permanent withdrawal of the dangerous medication, along with the use of duloxetine and physiotherapy as treatment. The patient progressed from severe neuropathy to mild neuropathy while achieving complete functional independence. The case demonstrates that personalized treatment plans and continuous patient evaluation help doctors achieve successful cancer treatment results while maintaining safe treatment methods which enhance both patient well-being and treatment results.[11]

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