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Case Series

Terminal lucidity in women with advanced gynecologic cancer: a case series and focused review of the literature

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ABSTRACT

Terminal lucidity (TL) is characterized by an unexpected, transient restoration of mental clarity, coherent communication, or purposeful behaviour shortly before death. Although reported in patients with neurodegenerative disorders, psychiatric illness, and pediatric oncology, TL has not previously been described in women with advanced gynaecological malignancies. We retrospectively reviewed 20 consecutive deaths among women with advanced gynaecological cancers at a tertiary gynaecologic oncology centre during 2025. Three patients fulfilled predefined criteria for TL and demonstrated an unexpected return of coherent communication and meaningful interaction following profound cognitive or functional decline. In each case, the episode occurred within 48 hours of death, allowing patients to communicate with family members and express personal wishes. Families uniformly interpreted the episodes as evidence of recovery despite the subsequent rapid clinical deterioration. These observations suggest that TL may occur in advanced gynaecological cancer and shares characteristic features with reports from neurological, palliative care, and pediatric oncology populations. Greater recognition of this phenomenon may facilitate appropriate counselling of families and improve end-of-life care, although prospective studies are needed to better define its incidence, underlying mechanisms, and clinical significance.

Keywords: Terminal lucidity, Terminal rally, Energy surge, Gynecologic cancer, Palliative care, End-of-life care

INTRODUCTION

Terminal lucidity (TL) refers to the unexpected, transient restoration of cognition, communication, memory, or purposeful behaviour shortly before death in individuals who have undergone substantial cognitive or functional decline. Although anecdotal descriptions have appeared in medical literature for centuries, systematic scientific investigation remains limited. Nahm and Greyson formalized the term in 2009 to describe such unexpected symptom remission in patients with severe psychiatric and neurological disease, and most subsequent reports continue to derive from dementia, schizophrenia, stroke,

and meningitis.¹ Comparatively little attention has been directed toward TL in advanced cancer, where transient improvement near death is more often attributed to fluctuating delirium, temporary metabolic stabilization, or caregiver misinterpretation.

The phenomenon nevertheless carries real clinical weight. Families frequently interpret these episodes as recovery, altering expectations and decision-making; conversely, TL may offer a genuine window for reconciliation, expressed wishes, and emotional closure. To our knowledge, no published case series has specifically examined TL in women with gynecologic

cancers, limiting clinicians' ability to recognize the phenomenon and counsel families appropriately. We present three such cases and discuss them against the existing literature.

CASE SERIES

20 consecutive deaths among women with advanced gynaecological cancers managed at a tertiary gynaecologic oncology centre during 2025 were reviewed retrospectively. Three patients met the predefined criteria for terminal lucidity (TL), defined as the unexpected restoration of coherent communication or purposeful interaction following significant cognitive or functional decline, occurring within seven days of death and without an identifiable reversible cause. Clinical records, physician observations, and documented caregiver accounts were reviewed to obtain demographic, clinical, and end-of-life characteristics, including the duration of

the lucid interval, time to death, and family perceptions. Consent was obtained from the patients' next of kin, and all patient identifiers were removed.

Case 1

A 50-year-old woman with recurrent platinum-resistant high-grade serous ovarian carcinoma developed progressive cachexia and an enterocutaneous fistula after failure of first-line treatment and was transitioned to end-of-life care. In the days preceding death she became progressively lethargic and drowsy, with minimal verbal interaction and cessation of oral intake. She then unexpectedly regained full awareness one morning, conversed coherently with her children, expressed personal thoughts, and requested tea. Family members interpreted this as evidence of recovery and expressed renewed hope. The episode lasted approximately 30 hours; she died roughly 36 hours after its onset.

Table 1: Clinical profile of cases showing TL.

Variables	Case 1	Case 2	Case 3
Age (years)	50	75	28
Diagnosis	Recurrent platinum-resistant HGSOC with enterocutaneous fistula	Metastatic cervical carcinoma with uremia	Metastatic malignant Brenner ovarian tumor
Consciousness before TL	Drowsy, minimally communicative	Unconscious	Reduced consciousness
Oral intake	Absent	Absent	Poor
Main feature of TL	Interaction with children, food craving	Emotional conversation with son	Discussion of goals and aspirations
Duration of TL	30 h	1 h	4 h
Time to death	36 h	4 h	10 h
Family interpretation	Miracle / recovery	Confusion and anxiety	Hope of recovery

Table 2. Shared clinical characteristics observed among patients experiencing TL

Clinical feature	Frequency
Marked reduction in consciousness before TL	3/3
Restoration of coherent communication	3/3
Meaningful interaction with relatives	3/3
Expression of personal wishes or emotions	3/3
Death within 48 hours of TL	3/3
Family interpreted event as recovery	3/3

Case 2

A 75-year-old woman with metastatic cervical carcinoma involving liver, bone, and soft tissue, and gross bilateral hydronephrosis (blood urea 250 mg/dL), presented with severe uremic encephalopathy and reduced

consciousness. During shifting to intensive care unit (ICU), she unexpectedly regained awareness and engaged in purposeful conversation with her son, discussing family affairs and personal wishes. No intervention capable of reversing the encephalopathy had been instituted beforehand. The lucid episode lasted

approximately one hour; she returned to her prior neurological state and died four hours later in the ICU.

Case 3

A 28-year-old woman with metastatic recurrent malignant Brenner tumor of the ovary, with extensive abdominal disease, hepatic and pulmonary metastases, severe cachexia, and inability to tolerate oral intake, showed progressive decline in consciousness and communication during the terminal phase. She then unexpectedly conversed at length with relatives about future aspirations, family relationships, and personal goals. The episode lasted approximately four hours; she suffered cardiorespiratory arrest and died roughly ten hours later.

Across all three cases, TL followed a marked reduction in consciousness and was characterized by restoration of coherent communication, meaningful interaction with relatives, and expression of personal wishes or emotions. Death occurred within 48 hours of the episode in every case, and families uniformly interpreted the event as a sign of recovery (Tables 1 and 2).

DISCUSSION

Terminal lucidity (TL) remains a rare and poorly understood end-of-life phenomenon characterized by the unexpected restoration of coherent cognition and meaningful communication shortly before death. Nahm et al. compiled 83 published cases spanning more than two centuries, involving patients with dementia, schizophrenia, stroke, meningitis, brain tumours, and other neurological disorders, demonstrating that TL occurs across diverse disease states but has been documented almost exclusively through anecdotal observations and case reports.² To our knowledge, this is the first case series documenting TL in women with advanced gynaecological malignancies.

A striking finding in our series was the remarkable consistency of the clinical pattern despite differences in age, tumour type, and disease burden. All three patients experienced profound cognitive or functional decline followed by an abrupt return of coherent communication and purposeful interaction immediately before death. Similar observations have been reported by Nahm et al who noted that the lucid interval typically enabled patients to recognize relatives, communicate meaningfully, and express previously inaccessible thoughts.^{1,2} Likewise, Perera et al in their 2025 systematic review of 21 studies, concluded that restoration of meaningful communication is the defining characteristic of TL, although variability in diagnostic definitions has limited comparisons across studies.³

The timing of TL in our patients also closely paralleled previous reports. Lucid episodes lasted between 1 and 30 hours, with death occurring 4–36 hours after onset in

every case. This is consistent with the observations of Lim et al., who found that terminal lucidity generally occurred within the final week of life and was followed by death within hours to a few days in most patients.⁴ Similarly, Julião et al described "energy surges" in hospice patients occurring during the last phase of life, characterized by transient restoration of alertness, communication, and social interaction before rapid clinical deterioration.⁵ Our patients exhibited many of these features, particularly restoration of communication, renewed engagement with family members, and discussion of unfinished personal matters.

An important observation in the present series was that none of the patients used the lucid interval to discuss medical issues. Instead, all conversations centred on family relationships, future aspirations, gratitude, or personal wishes. Similar themes have been described in qualitative studies of TL, where patients often use the final lucid period for emotional closure rather than symptom-related concerns.³ These interactions may therefore represent an important psychosocial opportunity for both patients and families.

Equally noteworthy was the uniform response of family members, all of whom interpreted the transient improvement as evidence of clinical recovery. This finding closely parallels previous reports describing renewed hope, confusion, and altered prognostic expectations among caregivers witnessing TL.^{3,6} Greater awareness of this phenomenon among oncologists and palliative care clinicians may facilitate anticipatory counselling, helping families understand that transient restoration of communication does not necessarily indicate reversal of the underlying disease while still allowing these episodes to be recognized as meaningful opportunities for reconciliation and expression of final wishes.

The biological basis of TL remains uncertain. Proposed mechanisms include transient reactivation of preserved neural networks, alterations in neurotransmitter signalling, metabolic changes during the dying process, and other neurophysiological adaptations, but none has been validated experimentally.^{2,3} The observation that similar clinical phenomena occur across neurodegenerative disorders, psychiatric illness, paediatric oncology, and now advanced gynaecological malignancies suggests that TL may represent a final common neurobiological pathway associated with the dying process rather than a disease-specific phenomenon.⁷

The present study has several strengths. It is, to our knowledge, the first report of TL in adult women with advanced gynaecological cancers and includes three cases identified from a retrospective review of consecutive deaths using a predefined operational definition. Detailed clinical documentation permitted characterization of the

timing, duration, behavioural features, and family perceptions of each episode.

However, several limitations should be acknowledged. The retrospective design introduces observer and recall bias, while the small sample size precludes estimation of incidence or identification of predictors. Objective neurocognitive or physiological assessment was unavailable, and although reversible causes such as delirium, metabolic disturbance, or medication effects were carefully considered, they cannot be excluded with absolute certainty. Furthermore, observations relied on physician documentation and caregiver accounts rather than standardized assessment instruments. Given the rarity and unpredictability of TL, prospective multicentre studies incorporating standardized diagnostic criteria and physiological monitoring are required to clarify its epidemiology, neurobiology, and implications for end-of-life care.

CONCLUSION

Terminal lucidity should be on the differential whenever a patient with advanced gynecologic cancer shows unexpected, transient restoration of communication near the end of life. Future studies should focus on systematic identification of TL episodes within oncology and palliative care services to better understand their frequency, clinical characteristics, and effect on family experiences at the end of life.

In the meantime, proactively naming this possibility to families - before it occurs - may be the single most useful intervention available to the bedside team, helping to prevent false hope while preserving the episode's value as an opportunity for connection and closure.

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