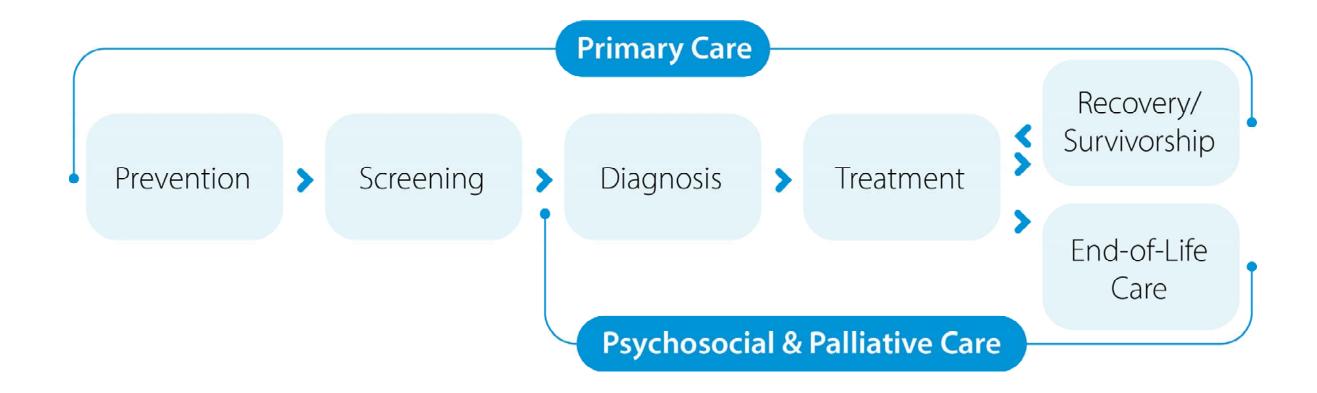
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Target Population

Patients with a confirmed breast cancer diagnosis who have undergone the recommended diagnostic and staging procedures outlined in the Breast Cancer Screening and Diagnosis Pathway Map.

Pathway Map Considerations

- Consider recommendation for exercise. For more information visit Exercise for people with cancer.
- For principles of synoptic pathology reporting and biomarker testing in breast cancer, see CAP guidelines and protocols www.cap.org.
- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, Health Care Connect is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see Person-Centered Care Guideline and EBS #19-2 Provider-Patient Communication.*
- Hyperlinks are used throughout the pathway map to provide information about relevant Ontario Health (Cancer Care Ontario) tools, resources and guidance documents.
- The term 'health care provider', used throughout the pathway map, includes primary care providers and specialists, nurse practitioners, and emergency physicians.
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on MCCs, visit MCC Tools.
- For more information on wait time prioritization, visit Surgery.
- Clinical trials should be considered for all phases of the pathway map.
- Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit EBS #19-3.*
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness:
 - Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care including restorative or rehabilitative care – or may become the total focus of care.
 - Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decisionmaking process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient's overall approach to care.

Pathway Map Legend

Colour Guide		Shape Guide		Line Guide	
Prima	ry Care		Intervention		Required
Palliat	ive Care	\Diamond	Decision or assessment point	•••••	Possible
Pathol	logy		Patient (disease) characteristics		
Surger	ry		Consultation with specialist		
Radiat	tion Oncology		Exit pathway		
Medic	al Oncology	\bigcirc or \bigcirc	Off page reference		
Radiol	logy	R	Ref erral		
	disciplinary Cancer rence (MCC)				
Genet	ics				
Psycho	osocial Oncology (PS	0)			

Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

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While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an "as-is" basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information's quality, accuracy, currency, completeness, or reliability.

Ontario Health (Cancer Care Ontario) and the pathway map's content providers (including the physicians who contributed to the information in the pathway map) shall have no liability, whether direct, indirect, consequential, contingent, special, or incidental, related to or arising from the information in the pathway map or its use thereof, whether based on breach of contract or tort (including negligence), and even if advised of the possibility thereof. Anyone using the information in the pathway map does so at his or her own risk, and by using such information, agrees to indemnify Ontario Health (Cancer Care Ontario) and its content providers from any and all liability, loss, damages, costs and expenses (including legal fees and expenses) arising from such person's use of the information in the pathway map.

This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway map on the same topic.

^{*} Note. EBS #19-3 is older than 3 years and is currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

EBS #1-10

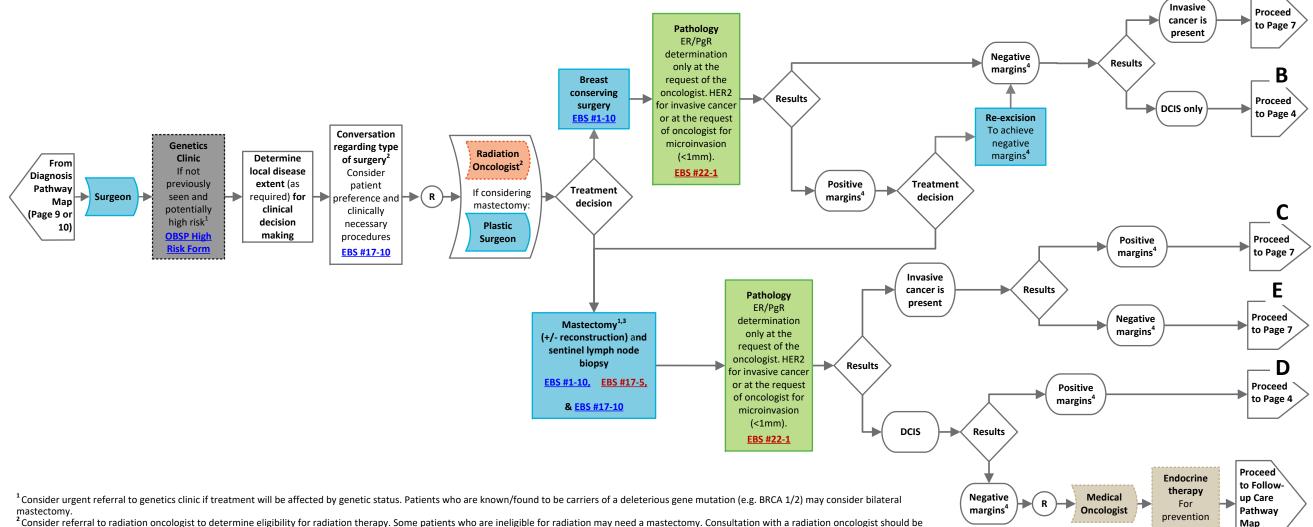
(Page 3)

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Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care

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²Consider referral to radiation oncologist to determine eligibility for radiation therapy. Some patients who are ineligible for radiation may need a mastectomy. Consultation with a radiation oncologist should be considered for patients who may be considered for immediate reconstruction.

Contralateral prophylactic mastectomy is **not** recommended for average risk women.

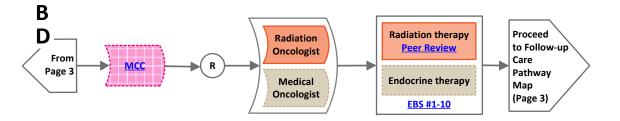
⁴ For the purpose of this pathway map, positive margins are defined as ink on tumour and the optimal negative margin width is > 2 mm. This definition has been adopted as per the Society of Surgical Oncology American Society for Radiation Oncology—American Society of Clinical Oncology Consensus Guideline on Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Ductal Carcinoma In Situ.

Ductal Carcinoma In Situ (contd)

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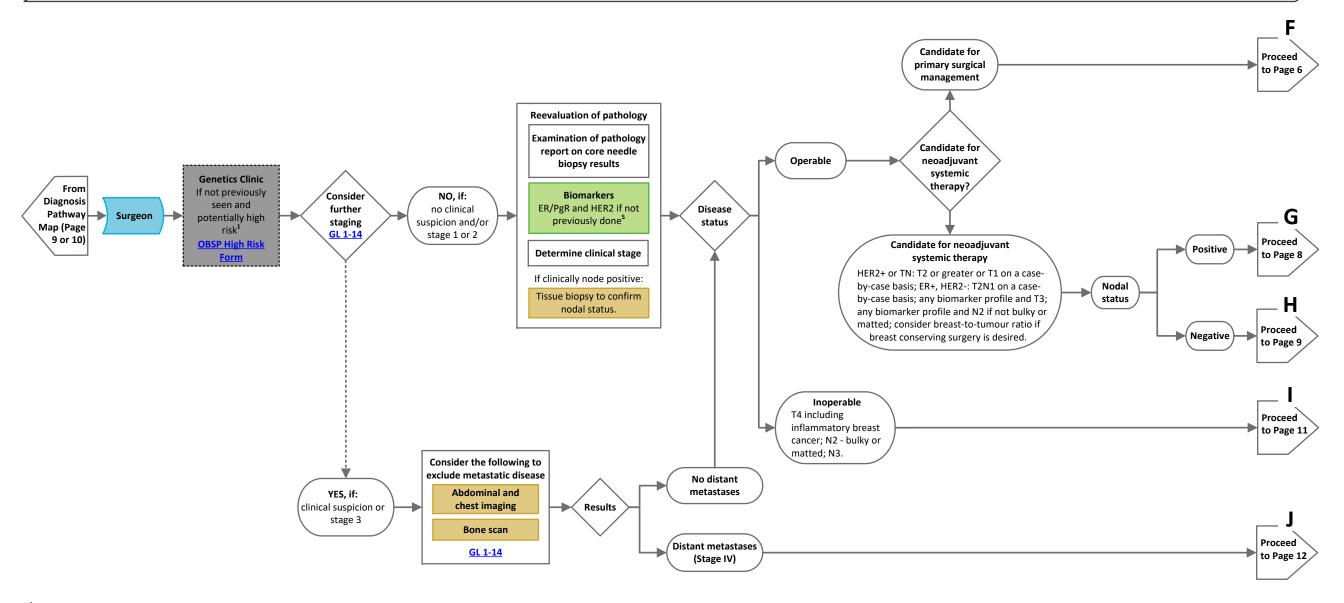


Invasive Breast Cancer: Assessment for Operability and Neoadjuvant Therapy

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¹Consider urgent referral to genetics clinic if treatment will be affected by genetic status. Patients who are known/found to be carriers of a deleterious gene mutation (e.g. BRCA 1/2) may consider bilateral mastectomy.

⁵ For more information about HER2 testing see ASCO (2013). Recommendations for HER2 receptor testing in breast cancer: American Society of Oncology/College of American Pathologist Clinical Practice Guideline Update. (Journal of Clinical Oncology, 2013, 31(31) 3997-4013).

Operable Invasive Breast Cancer: Candidates for Primary Surgical Management

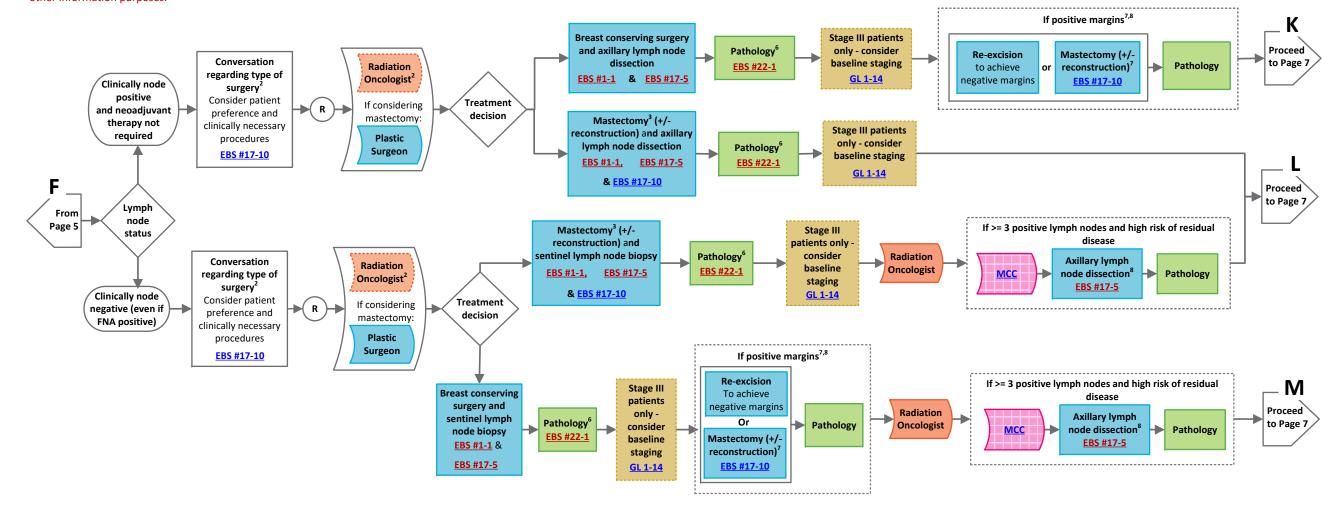
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² Consider referral to radiation oncologist to determine eligibility for radiation therapy. Some patients who are ineligible for radiation may need a mastectomy. Consultation with a radiation oncologist should be considered for patients who may be considered for immediate reconstruction.

³Contralateral prophylactic mastectomy is <u>not</u> recommended for average risk women.

⁶ If no cancer in surgical specimen (e.g. very small tumours, <1cm) refer to core biopsy pathology including biomarker testing.

⁷ For the purpose of this pathway map, negative margins are defined as no ink on tumor [no cancer cells adjacent to any inked edge/surface of the specimen] and positive margins are defined as ink on tumour. This definition has been adopted as per the American Society of Clinical Oncology guideline (Journal of Clinical Oncology, 2014, 32(14), 1502-1506).

⁸ May defer re-excision, mastectomy and axillary lymph node dissection until after systemic therapy if high risk of systemic recurrence.

Adjuvant Treatment Following Primary Surgical Management

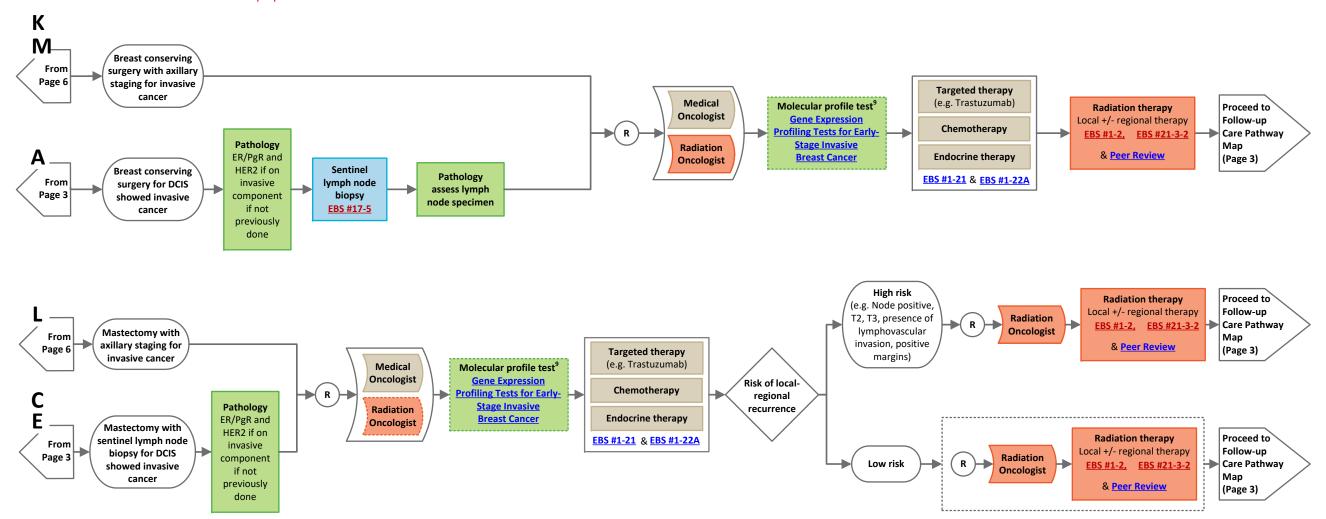
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⁹Candidates for molecular profile tests are patients with ER positive, HER2 negative, and lymph-node negative early-stage invasive breast cancer in whom the decision for chemotherapy is unclear.

¹⁰ Consider additional systemic options before considering other treatment options

Operable Invasive Breast Cancer: Node Positive Candidates for Neoadjuvant Therapy

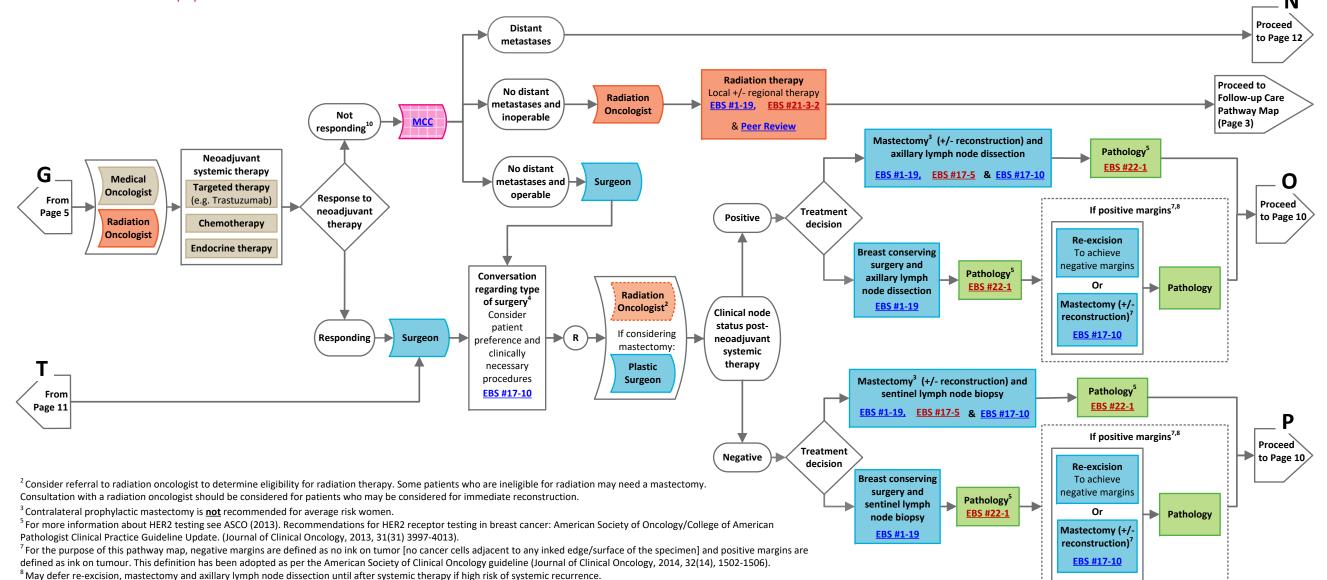
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Operable Invasive Breast Cancer: Node Negative Candidates for Neoadjuvant Therapy

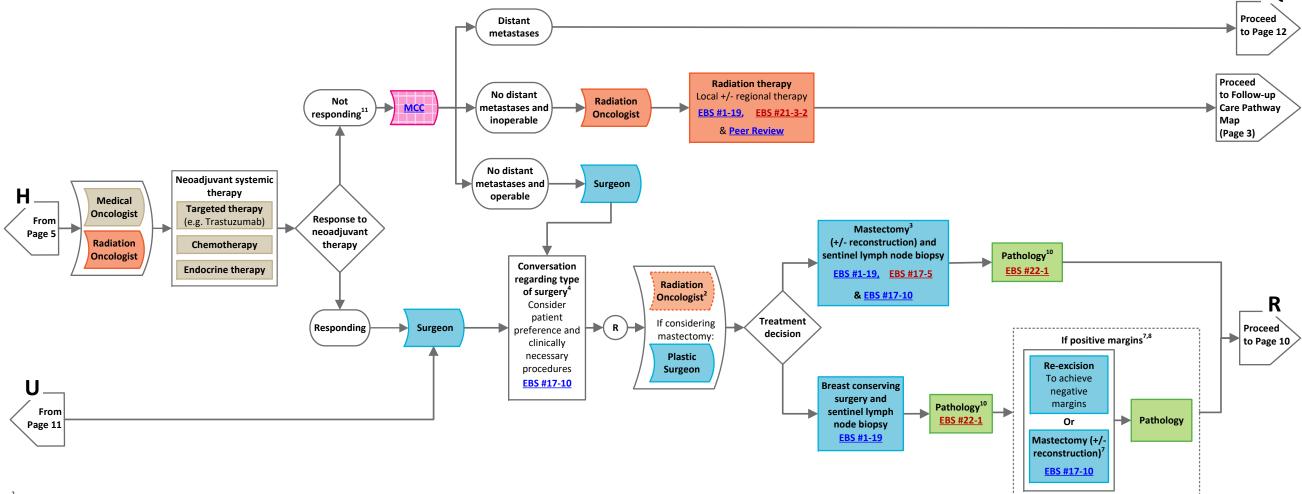
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⁸ May defer re-excision, mastectomy and axillary lymph node dissection until after systemic therapy if high risk of systemic recurrence.

¹¹ Consider additional systemic options before considering other treatment options.

Operable Invasive Breast Cancer: Candidates for Neoadjuvant Therapy (contd)

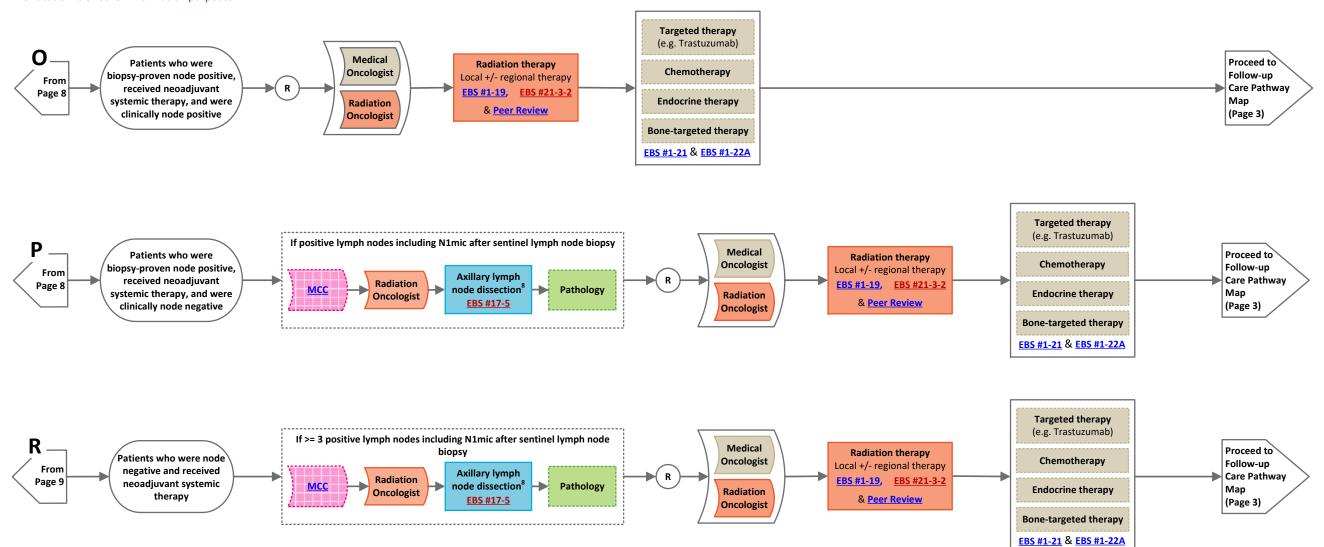
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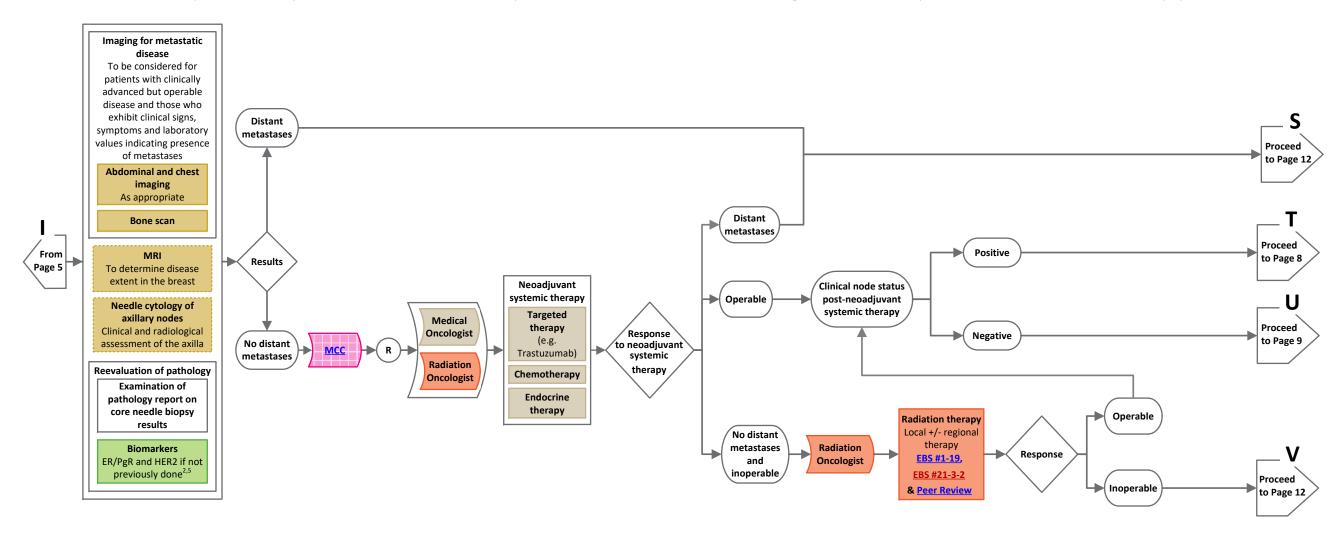


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⁵ For more information about HER2 testing see ASCO (2013). Recommendations for HER2 receptor testing in breast cancer: American Society of Oncology/College of American Pathologist Clinical Practice Guideline Update. (Journal of Clinical Oncology, 2013, 31(31) 3997-4013).

Distant Metastases (Stage IV or Locally Advanced and Unresectable)

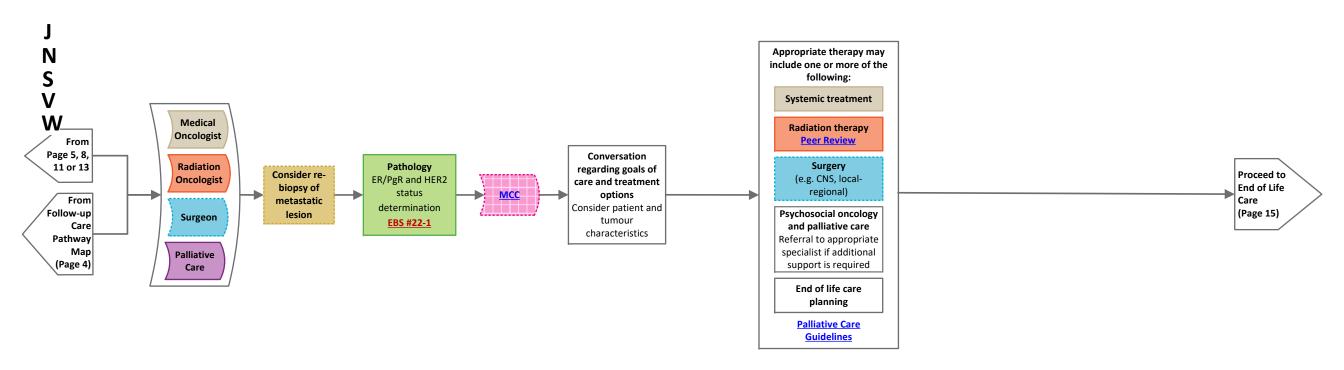
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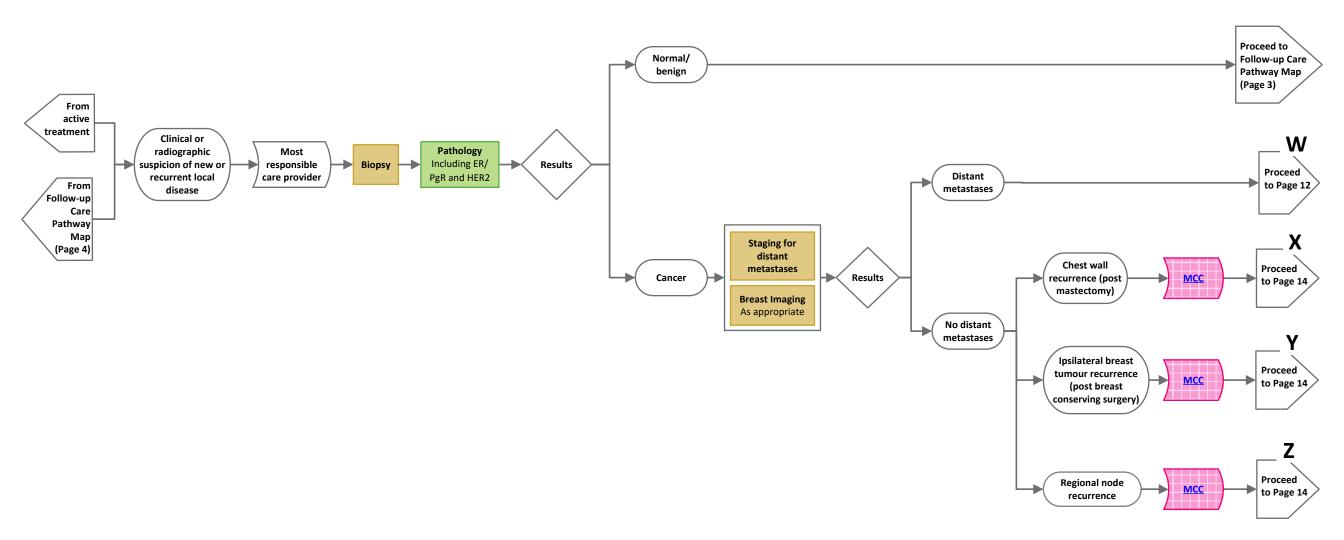
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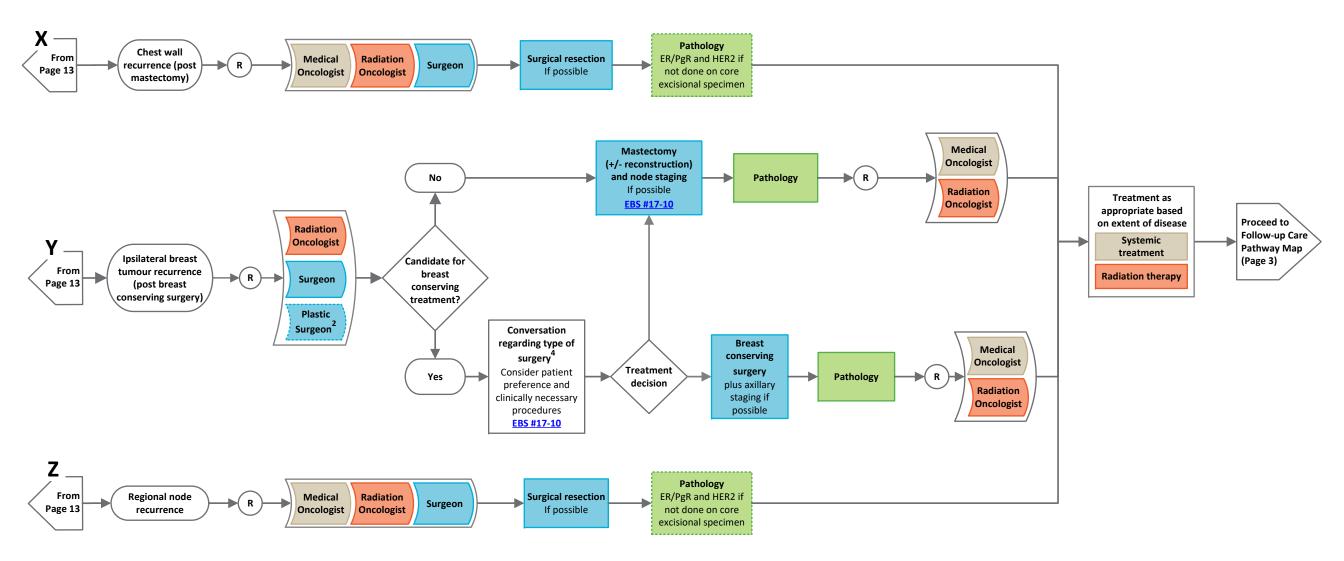
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End of Life Care

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Pathway Map Target Population:

Individuals with cancer approaching the last 3 months of life and their families.

While this section of the pathway is focused on the care delivered at the end of life, palliative care should be initiated much earlier in the illness trajectory. In particular, providers can introduce a palliative approach to care as early as the time of diagnosis.

Triggers that suggest patients are nearing the last few months and weeks of life

- ECOG/Patient-ECOG/PRFS = 4 OR
- PPS ≤ 50
- Declining performance status/functional ability

Screen, Assess, Plan, Manage and Follow Up



End of Life Care planning and implementation Collaboration and consultation between specialistlevel care teams and primary care teams



Conversations to determine where care should be provided and who will be responsible for providing the care

End of Life Care

☐ Key conversations to revisit Goals of Care and to discuss and document key treatment decisions

- Assess and address patient and family's information needs and understanding of the disease, address gaps between reality and
 expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
- Explore the patient's views on medications, tests, resuscitation, intensive care and preferred location of death
- If a patient makes any treatment decisions relevant to their current condition (i.e., provides consent), these decisions can be incorporated into their Plan of Treatment
- Review Goals of Care and patient preferences regularly, particularly when there is a change in clinical status

☐ Screen for specific end of life psychosocial issues

- Assess and address patient and families' loss, grief and bereavement needs including anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Provide appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and
 make referrals to available resources and/or specialized services to address identified needs as required
- · Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

□ Identify patients who could benefit from specialized palliative care services (consultation or transfer)

- As patient and family/caregiver needs increase and/or change over time consult with palliative care specialists and/or other providers
 with additional expertise, as required. Transfer care only if/when needs become more extensive or complex than the current team can
 handle
- Discuss referral with the patient and their family/caregiver

☐ Proactively develop and implement a plan for expected death

- Explore place-of-death preferences and the resources required (e.g., home, hospice, palliative care unit, long term care or nursing home) to assess whether this is realistic
- Prepare and support the family to understand what to expect, and plan for when a loved one is actively dying, including understanding
 probable symptoms, as well as the processes with death certification and how to engage funeral services
- Discuss emergency plans with patient and family (including who to contact, and when to use or avoid Emergency Medical Services)

☐ Home care planning (if this is where care will be delivered)

- Contact the patient's primary care and home and community care providers and relevant specialist physicians to ensure an effective transfer of information related to their care. If the patient is transitioning from the hospital, this should include collaborating to develop a transition plan
- Introduce patient and family to resources in community (e.g., respite, day hospice programs, volunteer services, support groups, etc.)
- Connect with home and community care services early (not just in the last 2-4 weeks)
- Ensure resources and services are in place to support the patient and their family/caregiver, and address identified needs
- Anticipate/plan for pain and symptom management, including consideration for a Symptom Response Kit to facilitate access to pain, dyspnea, and delirium medication for emergency purposes
- If the patient consents to withholding cardiopulmonary resuscitation, A 'Do Not Resuscitate' order must be documented in their medical record, and a Do Not Resuscitate Confirmation (DNR-C) Form should be completed. This form should be readily accessible in the home, to ensure that the patient's wishes for a natural death are respected by Emergency Medical Services

Patient Death	At the time of death: Pronouncement of death	Bereavement Support and Follow-Up Offer psychoeducation and/or counseling to the bereaved Screen for complicated and abnormal grief (family members, including children) Consider referral of bereaved family member(s) and children to appropriate local resources, spiritual advisor, grief counselor, hospice and other volunteer programs depending on severity of grief	Provide opportunities for debriefing of care team, including volunteers
	☐ Encourage the bereaved to make an appointment with an appropriate health care provider as required		