Clear Cell Epithelial Ovarian Cancer Treatment and Follow-up Pathway Map
Version 2018.06

The cancer journey
Better cancer services every step of the way

Disclaimer
The pathway map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway map. The information in the pathway map does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.
Target Population

- Women presenting with epithelial ovarian cancer

Pathway Map Considerations

- For more information about the optimal organization of gynecologic oncology services in Ontario refer to EBS #4-11
- The staging system used throughout the Ovarian Cancer Treatment Pathway Map is the 2014 FIGO staging system.
- 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 CCO tools, resources and guidance documents.
- The term ‘healthcare provider’, used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, gynecologists, midwives and emergency physicians.
- For more information on Multidisciplinary Cancer Conferences 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 oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. 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 decision-making 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

* Note. EBS #19-2 and EBS #19-3 are older than 3 years and are 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.

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. The pathway map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway map. The information in the pathway map does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader. While care has been taken in the preparation of the information contained in this 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. CCO 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 CCO 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.

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Suspicious Pelvic Mass with No Tissue Diagnosis, Presumed Clinical Early Stage

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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](#)

### From Diagnosis Pathway Map (Page 5)

- **Gynecologic Oncologist**
- **Sexual Health and Fertility Discussion**

### Oophorectomy

#### Pathologist

**Frozen Section Intraoperative Diagnosis**

- **EBG 84-15**

#### Primary Staging Surgery

- **Bilateral Salpingo-oophorectomy**
- **Total Hysterectomy**
- **Washings**
- **Omental biopsy**
- **Paraaortic and pelvic nodes**
- **Biopsy of other suspicious lesions**

#### Results

- **Pathologist**

### Advanced Stage

- **Proceed to Page 6**

### Non-ovarian Cancer

- **Refer to Appropriate Specialist**

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1. Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc.
2. Pathologists with a specialty or special interest in gynecologic pathology.
3. If appropriate, the option of fertility sparing surgery should be discussed with the patient.
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Primary Staging Surgery
- Bilateral Salpingo-oophorectomy
- Total Hysterectomy
- Staging - Washings
- Omental biopsy
- Paraortic and pelvic nodes
- Biopsy of other suspicious lesions

Confirmation of stage
IA or IB

IA or IB
Proceed to Page 5

From Diagnosis Pathway Map (Page 3, 4)
Clinical Stage IA, IB, or IC

Gynecologic Oncologist
Pathology Review

Sexual Health and Fertility Discussion

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

CT Abdomen Pelvis
CT Chest

Pathologist

Results
No evidence of extraovarian ovary cancer
Sexual Health and Fertility Discussion

Evidence of extraovarian ovary cancer

Primary Staging Surgery
- Bilateral Salpingo-oophorectomy
- Total Hysterectomy
- Staging - Washings
- Omental biopsy
- Paraortic and pelvic nodes
- Biopsy of other suspicious lesions

Pathologist

Confirmation of stage
IC

Other Stage
Proceed to Page 6

D
E
F
G

Pathologist

1 Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc.

2 Pathologists with a specialty or special interest in gynecologic pathology.
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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4 Referral to genetics if patient meets MOH criteria for genetic testing for Lynch syndrome
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

Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc.

Referral to genetics if patient meets MOH criteria for genetic testing for Lynch syndrome

To determine the appropriateness for surgery, the following should be taken into consideration: performance status, response to chemotherapy, surgical resectability, and patient comorbidities

The potential role of radiotherapy should be discussed at the MCC

When available, clinical trials are to be a priority in this patient population.

Follow-Up and Surveillance
Every 3 to 6 months (Year 1 and 2)
Every 6 to 12 months (Year 3 to 5)
then annually

Physical Exam and Full Pelvic Examination

Blood Test May Include:
• CA 125
• Other Tests as Clinically Indicated

Suspicion of Recurrence

Results

CT Abdomen Pelvis
CT Chest
Chest X-Ray
Blood Test to Include
CA 125

Recurrence

Recurrence

From Page 5, 6

Patients who have completed primary treatment and who are without evidence of disease

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

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*Annual follow-up by gynecologist, family doctor or gynecologic oncologist.
Screen for psychosocial needs, and assessment and management of symptoms. [Click here for more information about symptom assessment and management tools]

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7 When available, clinical trials are to be a priority in this patient population.

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M Referral to genetics if patient meets MOH criteria for genetic testing for Lynch syndrome

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When available, clinical trials are to be a priority in this patient population.
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End of Life Care

- Revisit Advance Care Planning
  - Ensure the patient has determined who will be their Substitute Decision Maker (SDM)
  - Ensure the patient has communicated to the SDM his/her wishes, values and beliefs to help guide that SDM in future decision making

- Discuss and document goals of care with patient and family
  - 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
  - Introduce patient and family to resources in community (e.g., day hospice programs)

- Develop a plan of treatment and obtain consent
  - Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable)
  - Develop a plan of treatment related to disease management that takes into account the person’s values and mutually determined goals of care
  - Obtain consent from the capable person or the substitute decision maker if the person is incapable for an end-of-life plan of treatment that includes:
    - Setting for care
    - Resuscitation status
    - Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.)

- Screen for specific end of life psychosocial issues
  - Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
  - Consider referral to available resources and/or specialized services

- Identify patients who could benefit from specialized palliative care services (consultation or transfer)
  - Discuss referral with patients and family

- Proactively develop and implement a plan for expected death
  - Explore place-of-death preferences and assess whether this is realistic
  - Explore the potential settings of dying and the resources required (e.g., home, residential hospice, palliative care unit, long term care or nursing home)
  - Anticipate/Plan for pain & symptom management medications and consider a Symptom Response Kit (SRK) for unexpected pain & symptom management
  - Preparation and support for family to manage
  - Discuss emergency plans with patient and family (who to call if emergency in the home or long-term-care or retirement home)

- Home care planning
  - Connect with Home and Community Care early (not just for last 2-4 weeks)
  - Ensure resources and elements in place
  - Consider a Symptom Response Kit (SRK) with access to pain, dyspnea and delirium medication
  - Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

Pathway Map Target Population:
- Individuals with cancer approaching end of life, and their families.

While this section of the pathway map is focused on the care delivered at the end of life, the palliative care approach begins much earlier in the illness trajectory. Refer to Screen, Assess & Plan within the Psychosocial & Palliative Care Pathway Map

Eastern Cooperative Oncology Group Performance Status (ECOG); Palliative Performance Scale (PPS); Patient Reported Functional Status (PRFS)

For more information on the Gold Standards Framework, visit http://www.goldstandardsframework.org.uk/
At the time of death:

- Pronouncement of death
- Completion of death certificate
- Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death
- Implement the pre-determined plan for expected death
- Arrange time with the family for a follow-up call or visit
- Provide age-specific bereavement services and resources
- Inform family of grief and bereavement resources/services
- Initiate grief care for family members at risk for complicated grief
- Encourage the bereaved to make an appointment with an appropriate health care provider as required

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