Mucinous Epithelial Ovarian Cancer Treatment and Follow-up Pathway Map

Disclaimer
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Pathway Map Preamble

**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 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](#).
- 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 healthcare 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.*

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### Pathway Map Legend

**Colour Guide**

- Primary Care
- Palliative Care
- Pathology
- Diagnostic Assessment Program (DAP)
- Gynecologic Oncology
- Radiation Oncology
- Medical Oncology
- Radiology
- Gynecology
- Genetics
- Multidisciplinary Cancer Conference (MCC)

**Shape Guide**

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off-page reference
- Referral
- Wait time indicator time point

**Line Guide**

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### 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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This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. CCO 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.
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.

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**Pathway Map:**

1. **From Diagnosis Pathway (Page 5)**
   - Gynecologic Oncologist
   - Sexual Health and Fertility Discussion

2. Oophorectomy
3. Frozen Section Intraoperative Diagnosis
4. Primary Staging Surgery:
   - Bilateral Salpingo-oophorectomy
   - Total Hysterectomy
   - Staging: Washings, Omental biopsy, Biopsy of other suspicious lesions, Appendectomy, Optional paraaortic and pelvic nodes

5. **Pathologist**
   - EBS #4-15

6. **Pathologist**
   - EBS #4-15

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**Pathway Details:**

- **Diagnosis:**
  - **Staged IA, IB, IC**
  - Proceed to Page 5
- **Advanced Stage**
  - Proceed to Page 6
  - **GI Evaluation**
    - Upper GI Endoscopy
    - Colonoscopy
    - Imaging as appropriate
  - Blood Tests:
    - CEA
    - CA 19-9
    - CA 125
  - **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.
Suspicious Pelvic Mass with Tissue Diagnosis, Presumed Clinical Early Stage

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Primary Staging Surgery:
- Bilateral Salpingo-oophorectomy
- Total Hysterectomy
- Staging - Washings - Omental biopsy - Biopsy of other suspicious lesions - Optional lymph node dissection - Appendectomy

Confirmation of stage
- IA, IB, IC
- Other Stage

Pathologist

Observation
EB5 #4-13

Evidence of extraovarian ovary cancer

No evidence of extraovarian ovary cancer

MCC

Results

Non-ovarian Cancer

Primary Staging Surgery

CT Abdomen Pelvis
CT Chest
Chest X-ray
Upper Gl Endoscopy
Colonoscopy
Blood Tests
- CEA
- CA 19-9
- CA-125

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

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

2 If appropriate, the option of fertility sparing surgery should be discussed with the patient.

Proceed to Page 5

IA, IB, IC

Proceed to Page 6

Refer to Appropriate Specialist

Appendix Cancer

Proceed to Page 6

Refer to Appropriate Specialist

Other Stage

Proceed to Page 6

Cases D and E both lead to Proceed to Page 6.

Cases C and F both lead to Proceed to Page 6.
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](#)
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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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. To determine the appropriateness for surgery, the following should be taken into consideration: performance status, response to chemotherapy, surgical resectability, and patient comorbidities.

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


5. Consider addition of Bevacizumab for front line treatment of ovarian cancer: 1) stage III suboptimally debulked; 2) stage III unresectable; 3) stage IV. Refer to CCO appropriate Bevacizumab Eligibility Form.

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H: No Visible Residual Disease
Proceed to Page 7

I: Visible Residual Disease
Proceed to Page 7

J: Progression
Refer to Appropriate Specialist

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From Diagnosis Pathway (Page 3)

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B: From Page 3, 4

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D: From Page 3, 4

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F: From Page 4

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Gynecologic Oncologist
Sexual Health and Fertility Discussion

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CT Abdomen Pelvis
CT Chest
Upper GI Endoscopy
Colonoscopy
Imaging and GI Evaluation (if not already performed)

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Blood Tests
- CEA
- CA 19-9
- CA 125

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Biopsy
Pathologist EBS #4-15
Pathologist

---

Appropriate for surgery

---

Intraoperative Diagnosis

---

Frozen Section

---

Primary Cytoreductive Surgery
- Bilateral Salpingo- oopherectomy
- Total Hysterectomy
- Possible Cytoreductive Surgery
- Appendectomy

---

Pathologist EBS #4-15

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Suspicion of non-gynecological primary

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Pathologist

---

Not appropriate for surgery

---

Upper GI Endoscopy
Colonoscopy
Blood Tests

---

End of life care planning

---

Clinical Trials
EBS #4-3

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Intravenous Systemic Therapy
EBS #4-3

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Psychosocial oncology and supportive care
Referral to appropriate specialist if additional support is required

---

End of life care planning

---

Considering palliative care, early and across the cancer journey Click here for more information about palliative care

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Medical Oncologist
Palliative Care

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Pathologist

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Progression

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End of life care planning (Page 10)
Mucinous Epithelial Ovarian Cancer Treatment and Follow-up Pathway Map

Advanced Stage CONT'D

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

Consider addition of Bevacizumab for front line treatment of ovarian cancer: 1) stage III suboptimally debulked; 2) stage III unresectable; 3) stage IV. Refer to CCO for appropriate Bevacizumab Eligibility Form.

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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Observation EBS #4-13

Intravenous Systemic Therapy

Or

Clinical Trials

EBS #4-3

Or

Intravenous Systemic Therapy

EBS #4-3

Psychosocial oncology and supportive care

Referral to appropriate specialist if additional support is required

End of life care planning

Progression

Proceed to End of life care (Page 10)

Patient Choice

Residual Disease

Gynecologic Oncologist

Medical Oncologist

Palliative Care

Medical Oncologist

Gynecologic Oncologist

H

From Page 6

R

MCC

J

Proceed to Page 8

I

From Page 6

No Residual Disease

MCC

End of life care planning

Medical Oncologist

Palliative Care

Patient Choice

Medical Oncologist

Gynecologic Oncologist

Or

Intravenous Systemic Therapy

Or

Clinical Trials

EBS #4-3

Or

Intravenous Systemic Therapy

EBS #4-3

Psychosocial oncology and supportive care

Referral to appropriate specialist if additional support is required

End of life care planning

Progression

Proceed to End of life care (Page 10)

Patient Choice

Residual Disease

Gynecologic Oncologist

Medical Oncologist

Palliative Care

Medical Oncologist

Gynecologic Oncologist

H

From Page 6

R

MCC

J

Proceed to Page 8

I

From Page 6

No Residual Disease

MCC

End of life care planning

Medical Oncologist

Palliative Care

Patient Choice

Medical Oncologist

Gynecologic Oncologist

Or

Intravenous Systemic Therapy

Or

Clinical Trials

EBS #4-3

Or

Intravenous Systemic Therapy

EBS #4-3

Psychosocial oncology and supportive care

Referral to appropriate specialist if additional support is required

End of life care planning

Progression

Proceed to End of life care (Page 10)

Patient Choice

Residual Disease

Gynecologic Oncologist

Medical Oncologist

Palliative Care

Medical Oncologist

Gynecologic Oncologist

H

From Page 6

R

MCC

J

Proceed to Page 8

I

From Page 6

No Residual Disease

MCC

End of life care planning

Medical Oncologist

Palliative Care

Patient Choice

Medical Oncologist

Gynecologic Oncologist

Or

Intravenous Systemic Therapy

Or

Clinical Trials

EBS #4-3

Or

Intravenous Systemic Therapy

EBS #4-3

Psychosocial oncology and supportive care

Referral to appropriate specialist if additional support is required

End of life care planning

Progression

Proceed to End of life care (Page 10)
Follow-Up Care

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Follow-Up and Surveillance

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

**Physical Exam and Full Pelvic Examination**

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

**Suspicion of Progression**

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

**No Progression**

Every 3 to 6 months (Year 1 and 2)
Every 6 to 12 months (Year 3 to 5) then annually

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

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

* Annual follow-up by gynecologist, family doctor or gynecologic oncologist.

Proceed to Page 9
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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* When available, clinical trials are to be a priority in this patient population
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

**Triggers that suggest patients are nearing the last few months and weeks life**
- ECOG/ECOG/PRFS = 4 OR
- PPS ≤ 30
- Declining performance status/functional ability
- Gold Standards Framework indicators of high mortality risk

**Screen, Assess, Plan, Manage and Follow-Up**

**End of Life Care planning and implementation**

Collaboration and consultation between specialist-level care teams and primary care teams

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/](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