Prostate Cancer Treatment Pathway
Version 2018.03

Disclaimer
The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. 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. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.
Target Population
Patients with a confirmed prostate cancer diagnosis who have undergone the recommended diagnostic and staging procedures outlined in the Prostate Cancer Diagnosis Pathway.

Pathway Map Considerations
- 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 family 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 ‘health care provider’, used throughout the pathway map, includes primary care providers and specialists, nurse practitioners, and emergency physicians.
- Counseling and treatment for smoking cessation should be initiated early on in the pathway map and continued by care providers throughout the pathway map as necessary. Program Training & Consultation Centre – Hospital Based Resources.
- In order to minimize delays, processes may be carried out in parallel if disease management is not affected.
- 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: (1) 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. (2) 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.
- For more information on the systemic treatment QBP please refer to the Quality-Based Procedures Clinical Handbook for Systemic Treatment.
- Note. EBS #19-2 and EBS #19-3 are 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.

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

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. 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. The information in the pathway 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 the pathway, 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’s content providers (including the physicians who contributed to the information in the pathway) shall have no liability, whether direct, indirect, consequential, contingent, special, or incidental, related to or arising from the information in the pathway 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 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.

This pathway 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. It is possible that other relevant scientific findings may have been reported since completion of this pathway. This pathway may be superseded by an updated pathway on the same topic.
**Prostate Cancer Treatment Pathway**

**Low Risk** (must include all of the following):
- T1-T2a, Gleason score $\leq 6$,
- PSA $\leq 10$ng/mL

**From Diagnosis Pathway** (Page 5)

**Watchful Waiting**
Ongoing assessment for symptoms and monitoring development of metastatic disease. Frequency up to discretion of managing physician
- PSA Test, DRE, Imaging as indicated

**Active Surveillance** EBS #17-9
- PSA Test every 3-6 months
- Confirmatory TRUS biopsy within 6-12 months (minimum 12 cores)
- Serial biopsy at a minimum every 3-5 years thereafter or suspected disease progression

**External Beam Radiation Therapy**
Brachytherapy
Radical Prostatectomy
- Open, laparoscopic or robotic-assisted

**Standard Pelvic Lymph Node Dissection**
- EBS #17-3
- Quality-Based Procedures Clinical Handbook for Cancer Surgery

**Multiparametric MRI**
If discordance between clinical and pathological findings or suspected disease progression

**Life expectancy $<10$ years**
- DRE every year
- Serial biopsy at a minimum every 3-5 years thereafter

**Assess candidacy for curative treatment** (e.g. comorbidities, life expectancy, patient preference)

**Consultations to discuss ALL treatment options**
- Radiation Oncologist
- Urologist

**Patient candidate for curative treatment**
- Assess candidacy for curative treatment
- From Diagnosic Pathway (Page 5)

**No**
- Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

**Yes**
- **Assess candidacy for curative treatment**
- **From Diagnosic Pathway** (Page 5)

**Patient’s treatment decision**
- **No**
  - **Consultations to discuss ALL treatment options**
    - Radiation Oncologist
    - Urologist
  - **Yes**
    - **Radical Prostatectomy**
      - Open, laparoscopic or robotic-assisted
      - EBS #17-3
      - Standard Pelvic Lymph Node Dissection
      - EBS #17-3
      - Quality-Based Procedures Clinical Handbook for Cancer Surgery
    - **Radical Prostatectomy**
      - **Guideline 3-A-2016-1**
    - **Brachytherapy**
      - **Guideline 3-A-2016-1**
    - **External Beam Radiation Therapy**
      - **Peer Review**

1 If low risk prostate cancer patients are seeking definitive treatment, a radiation oncology consultation should be sought.
The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. 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. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

### External Beam Radiation Therapy

- **Brachytherapy**
- **Radical Prostatectomy**
  - Open, laparoscopic or robotic-assisted
- **Standard Pelvic Lymph Node Dissection**

### Combined Modality Treatment

- Brachytherapy
- External Beam Radiation Therapy
- Combined Modality Treatment (Brachytherapy and External Beam Radiation Therapy)

### Watchful Waiting

- Ongoing assessment for symptoms and monitoring development of metastatic disease. Frequency up to discretion of managing physician
- PSA Test, DRE, Imaging as indicated

### Quality-Based Procedures

- Clinical Handbook for Cancer Surgery
- Peer Review

---

2 Active surveillance may be considered for a highly selective subset of patients in the intermediate risk group presenting with the following features: Stage ≤ T2a, Gleason score 7, T2b, and asymptomatic for metastases.

3 Neoadjuvant/adjuvant androgen deprivation therapy can be considered for select patients.
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
Low/Intermediate/High Risk continued

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. 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. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Prostate Cancer Treatment Pathway

Adjuvant External Beam Radiation Therapy
Within 6-18 weeks following prostatectomy

Yes, if one or more of the following: surgical margins positive, post-prostatectomy PSA is rising and is > 0.1ng/mL

Observation

No

Further treatment required?

Yes

Patient candidate for adjuvant treatment?

No

Yes

Patient considers options

Patient’s treatment decision

Adjuvant External Beam Radiation Therapy
Within 6-18 weeks following prostatectomy

Early referral recommended, refer to EBS #3-17 (This document is archived)

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
**Metastatic/Secondary Recurrence - Hormone Naïve**

**Prostate Cancer Treatment Pathway**

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. 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. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

**Secondary Hormone Manipulation**

1. **Orchiectomy**
2. Select patients with nodal involvement can be managed with the high risk/locally advanced pathway
3. High volume defined as visceral metastases and/or 4 or more bone metastases (at least 1 beyond pelvis and vertabral column)
4. Limited course of docetaxel to androgen-deprivation therapy in the setting of newly diagnosed metastatic androgen-sensitive prostate cancer, refer to **EBS #3-15**
5. Secondary Hormone Manipulation may include: antiandrogen, antiandrogen withdrawal, antiandrogen switch, luteinizing hormone releasing hormone (LHRH) switch, ketoconazole, or steroids


**Intermittent Androgen Deprivation Therapy**

**Optimize bone health**

**Frequent PSA Test, Testosterone Levels, Follow-up Imaging Tests**

**Screen for psychosocial needs, and assessment and management of symptoms.**

**Note:** EBS #3-1 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.

**The appearance of specific drugs on this pathway does not imply that the drugs are publicly funded.**

**Follow-up / Surveillance Scheduling can vary.** Managed by the treating physician.

**Response evaluation**

**Response**

**Progression**

**Page 8 for Secondary Hormone Manipulation or page 9 for Castrate Resistant Prostate Cancer (CRPC) depending on prior treatments and/or current presentation.**

---

**From Treatment Pathway Pages 3, 4, 5, or 7**

**From Diagnosis Pathway (Page 5)**

**Negative Bone Scan and CT**

**Androgen Deprivation Therapy (ADT)**

**Bone Scan and X-ray of suspicious areas**

**Imaging Tests**

**CT Abdomen/Pelvis**

**Pelvic MRI**

**Follow-up / Surveillance**

**Optimal bone health**

**PSA Test, Testosterone Levels, Imaging**

**Medical Oncologist**

**Radiation Oncologist**

**Urologist**

**PSA Test, Imaging - As needed**

**Consider ADT when PSA >5ng/mL, and/or PSA doubling time <3 months**

**Intermittent Androgen Deprivation Therapy**

**Orchiectomy**

**Optimize bone health 3-14x2**

**PSA Test, Testosterone Levels Frequency determined by treating physician**

**Secondary Hormone Manipulation**

**Response Evaluation**

**PSA rising and testosterone at castrate levels**

**Follow-up / Surveillance Scheduling may vary.** Managed by the treating physician.
Prostate Cancer Treatment Pathway

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. 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. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

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 on in the illness trajectory. Refer to Screen, Assess & Plan within the Psychosocial & Palliative Care Pathway Map.

End of Life Care (refer to Collaborative Care Plan)

- 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/Patient-ECOG/PRFS = 4
- 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

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

+ Screen, Assess & Plan
within the Psychosocial & Palliative Care Pathway Map

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