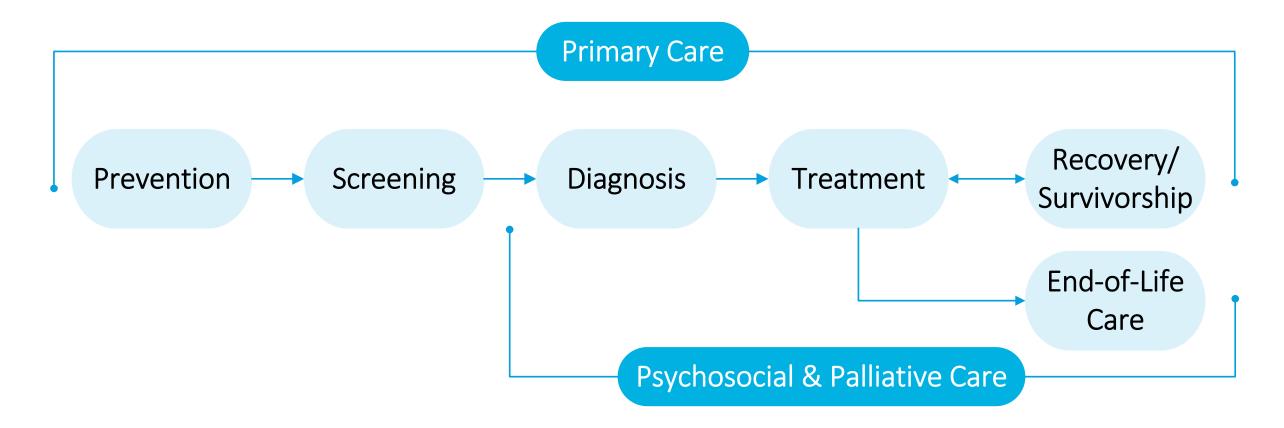
# **Cervical Cancer Follow-Up Pathway Map**

Version 2025.06



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Line Guide

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### **Target Population**

Cervical cancer survivors: adult patients who are clinically disease free after receiving primary treatment with curative intent for cervical cancer.

### **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, <u>Health Care Connect</u> 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 <a href="Person-Centered Care Guideline">Person-Centered Care Guideline</a> and <a href="EBS #19-2 Provider-Patient Communication.">EBS #19-2 Provider-Patient Communication.</a>\*
- 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, e.g. family doctors, nurse practitioners, and emergency physicians.
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on Multidisciplinary Cancer Conferences, visit MCC Tools.
- For more information on wait time prioritization, visit <u>Surgery</u>.
- 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 <a href="EBS #19-3.">EBS #19-3.\*</a>

# \* Note. <u>EBS #19-2</u> and <u>EBS #19-3</u> 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 Legend**

Colour Guide

Colour Guide		Shape dalac		Line Galac		
		Primary Care		Intervention		Require
		Palliative Care	$\Diamond$	Decision or assessment point	•••••	Possible
		Pathology		Patient (disease) characteristics		
		Organized Diagnostic Assessment		Consultation with specialist		
		Surgery		Exit pathway		
		Radiation Oncology	$\bigcirc or \bigcirc$	Off page reference		
		Medical Oncology	R	Referral		
		Radiology				
		Multidisciplinary Cancer Conference (MCC)				
		Genetics				
		Psychosocial Oncology (P	SO)			

Shane Guide

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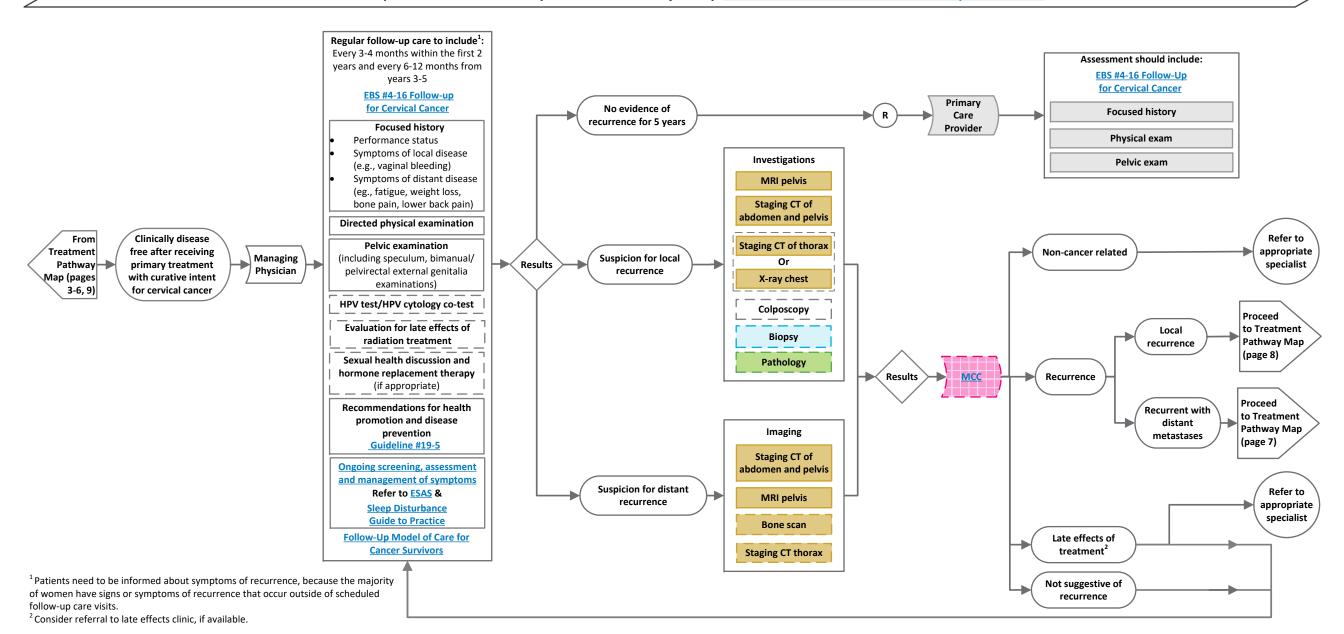
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Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

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



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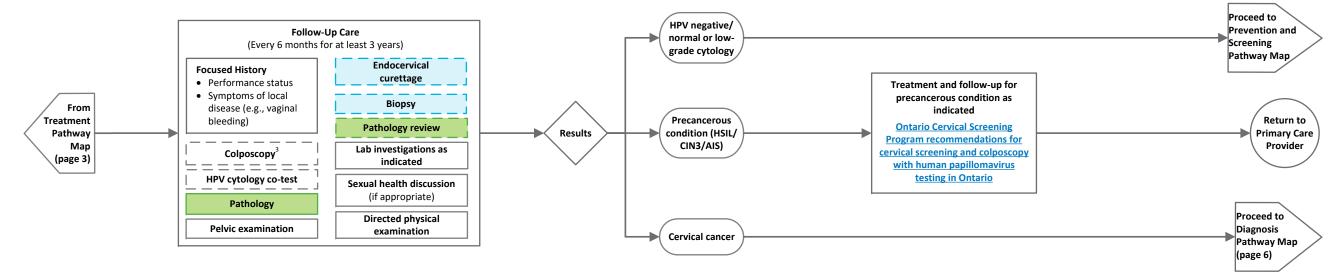
# Follow-Up for Stage IA1 Treated with Fertility Preservation

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<sup>&</sup>lt;sup>3</sup>Perform colposcopy if treated with excisional procedure and uterus/cervix is in situ.

## **Cervical Cancer Follow Up Pathway Map**

**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

Eastern
 Cooperative
 Oncology Group
 (ECOG)
 Performance
 Status/Patient ECOG/Patient
 Reported
 Functional Status
 (PRFS) = 4

Palliative Performance Scale (PPS) ≤ 50

OR

 Declining performance status/functional ability 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



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

## **Cervical Cancer Follow Up Pathway Map**

**End of Life Care, continued** 

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Provide opportunities for debriefing of care team, including volunteers

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	At the time of death:			
	☐ Pronouncement of death			
	☐ Completion of death certificate			
	$\square$ 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		Bereavement Support and Follow-Up	
	☐ 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		☐ Offer psychoeducation and/or counseling to the bereaved ☐ Screen for complicated and abnormal grief (family members,	
—Patient Death		<b>•</b>	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	
	☐ Inform family of grief and bereavement resources/		on severity of grief	
	☐ 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			

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