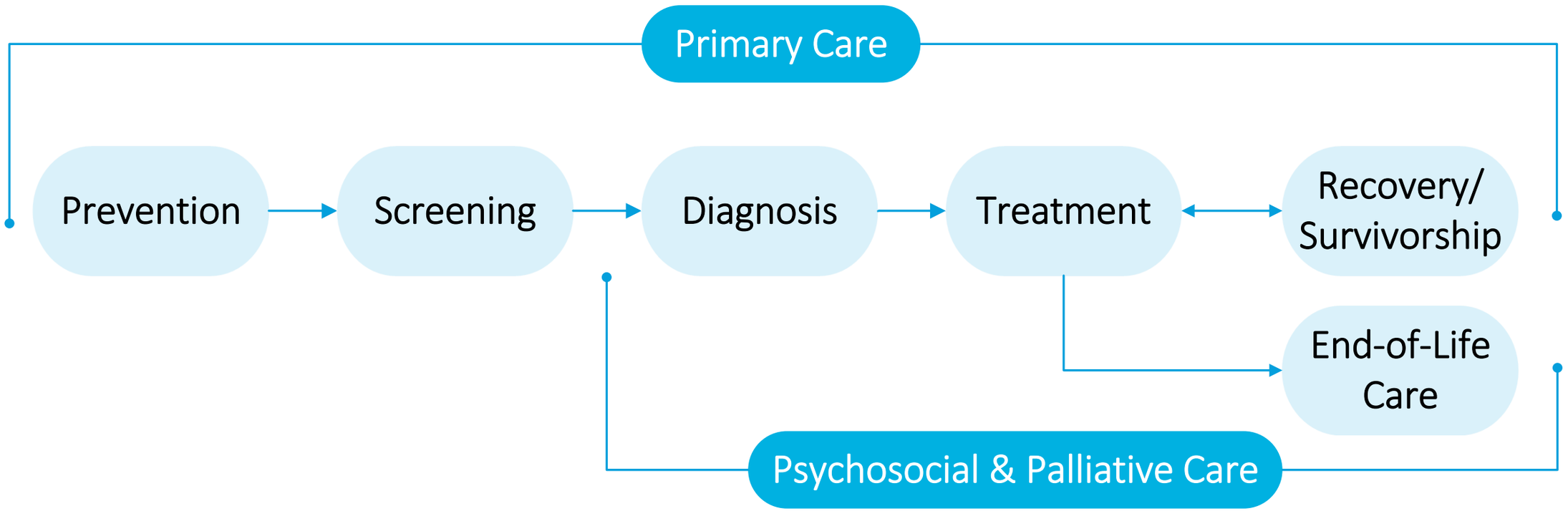
Cervical Cancer Treatment Pathway Map

Version 2025.06



Ontario Health
Cancer Care Ontario

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Target Population

Patients with a confirmed diagnosis of cervical cancer who have undergone the recommended diagnostic and staging procedures outlined in the Cervical Cancer Diagnosis Pathway Map. This pathway map is not intended for patients diagnosed with rare cervical cancer/rare cervical tumours.

Pathway Map Considerations

- For more information about the optimal organization of gynecologic oncology services in Ontario, refer to EBS #4-11.
- **Staging:** The classification and staging system used is the 2018 FIGO Staging for Cervical Cancer.
- Sexual health should be considered throughout the care continuum. Healthcare providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See Psychosocial Oncology Guidelines Resources.
- Before initiating gonadotoxic therapy (e.g. surgery, systemic, radiation), healthcare providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See Ontario Fertility Program.
- 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, Health811 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, 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 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.*

Pathway Map Legend

Colour Guide

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

Shape Guide

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

Line Guide

- Required
- Possible

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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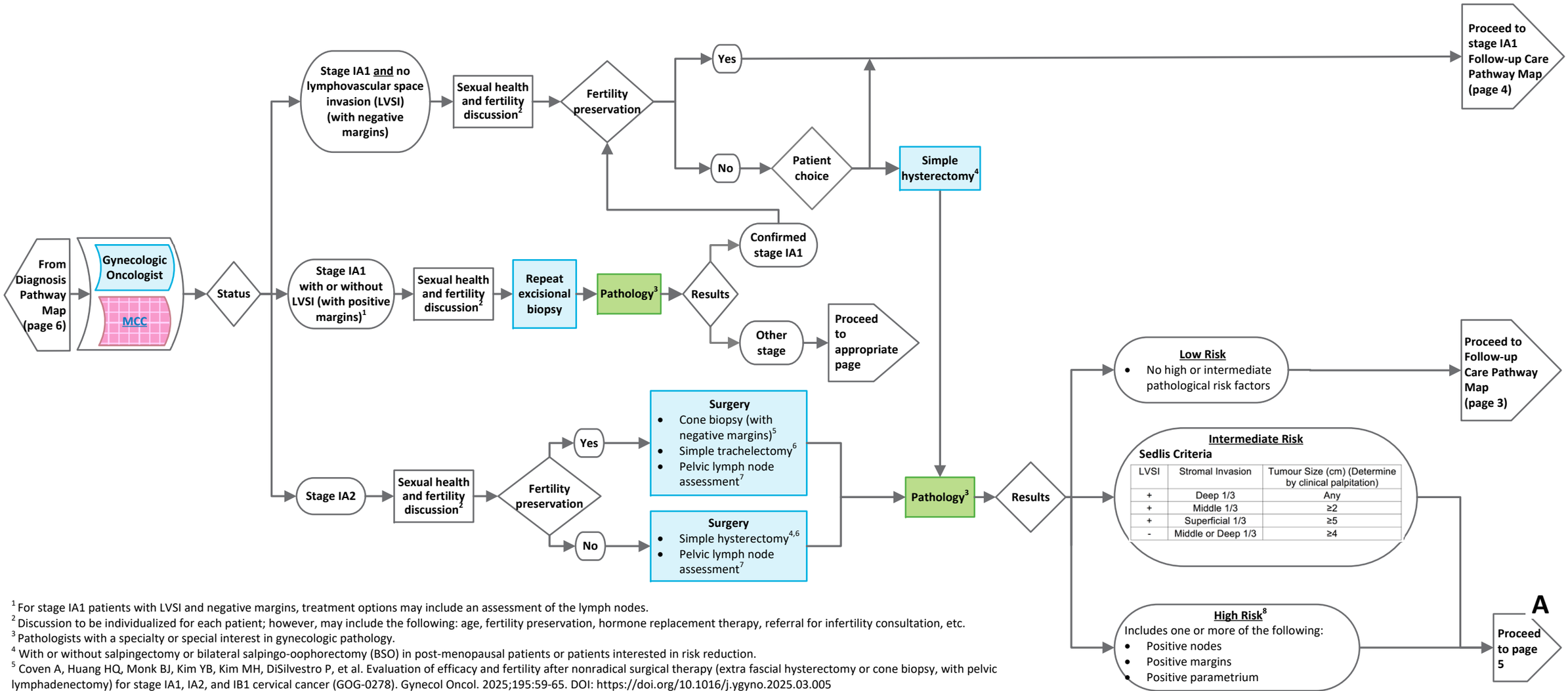
* **Note.** EBS #19-2 is older than 3 years and is currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

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



[1] For stage IA1 patients with LVSI and negative margins, treatment options may include an assessment of the lymph nodes.
[2] Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc.
[3] Pathologists with a specialty or special interest in gynecologic pathology.
[4] With or without salpingectomy or bilateral salpingo-oophorectomy (BSO) in post-menopausal patients or patients interested in risk reduction.
[5] Coven A, Huang HQ, Monk BJ, Kim YB, Kim MH, DiSilvestro P, et al. Evaluation of efficacy and fertility after nonradical surgical therapy (extra fascial hysterectomy or cone biopsy, with pelvic lymphadenectomy) for stage IA1, IA2, and IB1 cervical cancer (GOG-0278). Gynecol Oncol. 2025;195:59-65. DOI: https://doi.org/10.1016/j.ygyno.2025.03.005
[6] Plante M, Kwon JS, Ferguson S, Samouelian V, Ferro G, Maulard A, et al. Simple versus radical hysterectomy in women with low-risk cervical cancer. N Engl J Med. 2024 Feb 29;390(9):819-829.
[7] Sentinel lymph node dissection is the preferred nodal assessment practice.
[8] Completion of hysterectomy should be considered for patients who have undergone a trachelectomy and whose final pathology includes high risk features.

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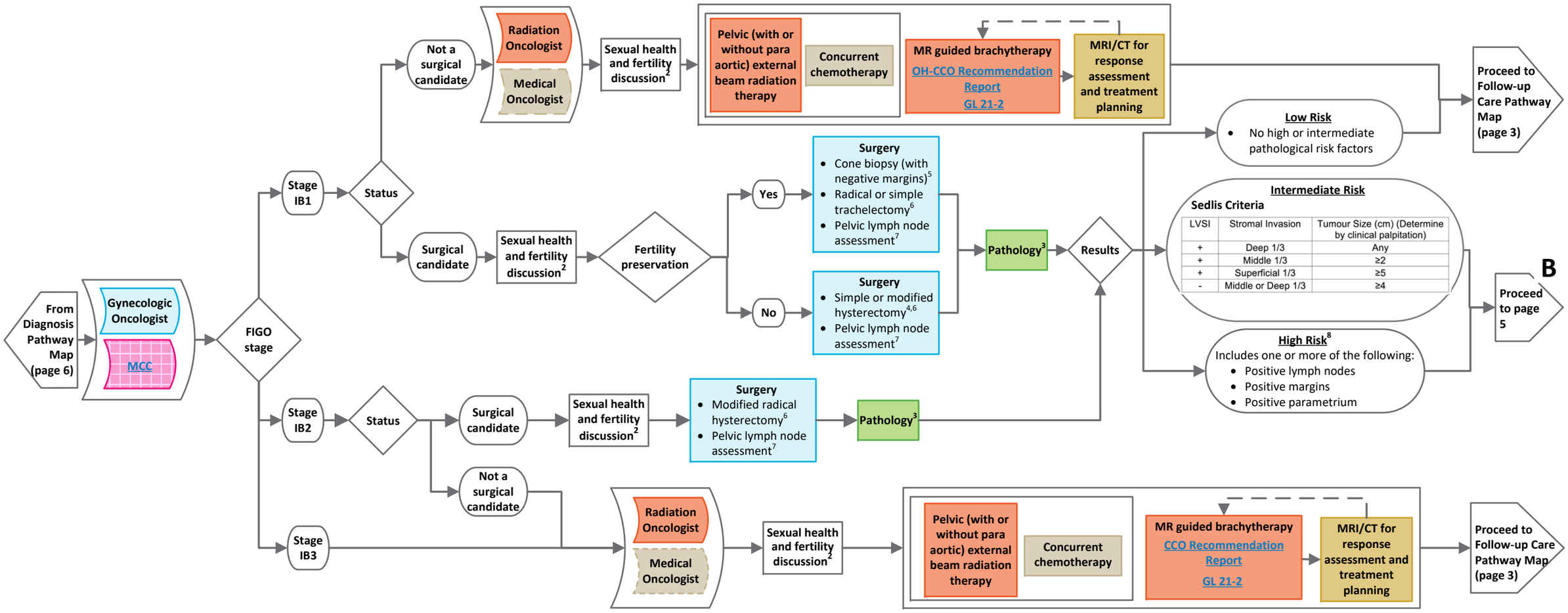

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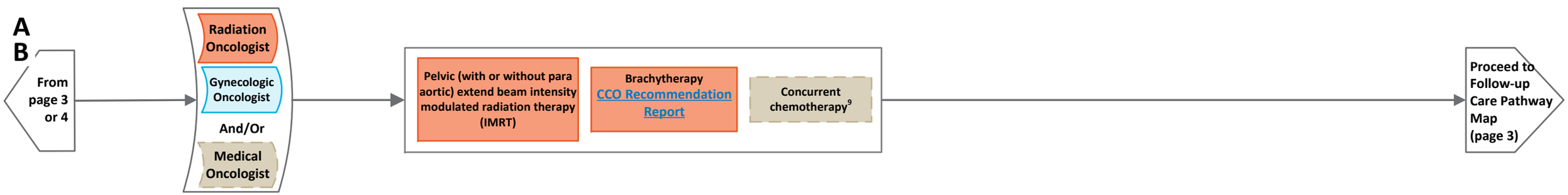

[9] Concurrent chemotherapy recommended for patients with “high” risk pathologic feature and may be considered for “intermediate” risk pathologic features.

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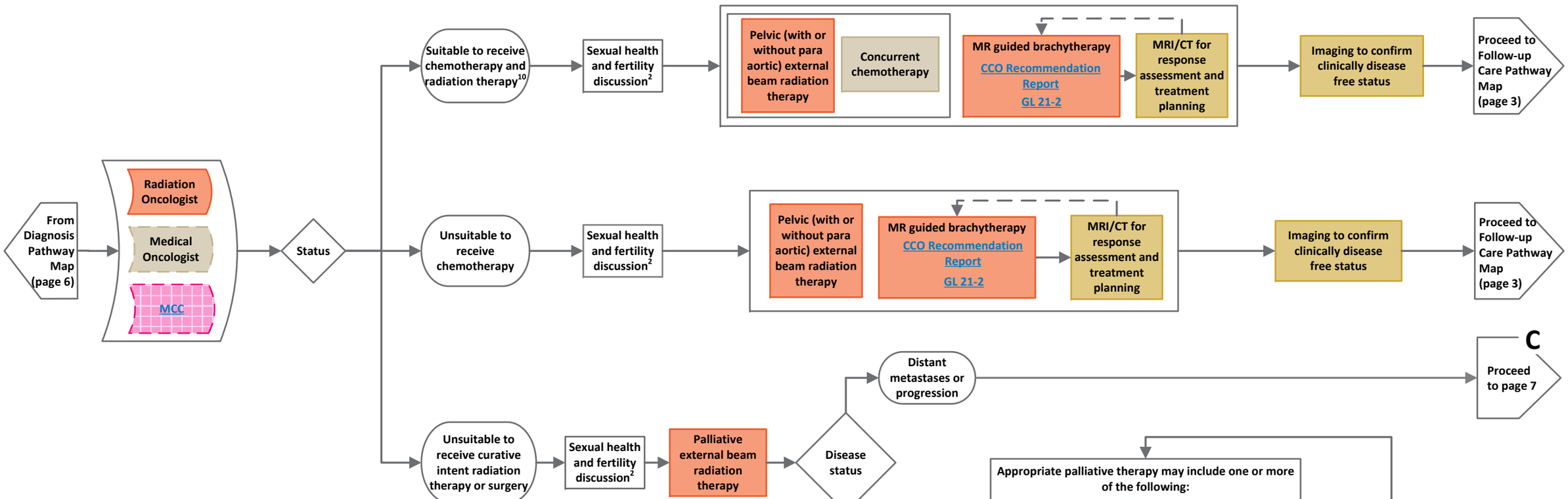

[2] Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc.

[10] For locally advanced cervical cancer treated with chemotherapy and radiation, neoadjuvant chemotherapy may be considered. McCormack M, Eminowicz G, Gallardo D, Diez P, Farrelly L, Kent C, et al. Induction chemotherapy followed by standard chemoradiotherapy versus standard chemoradiotherapy alone in patients with locally advanced cervical cancer (GCIG INTERLACE): an international, multicentre, randomised phase 3 trial. Lancet. 2024; 404 (10462): 1525-35. DOI: https://doi.org/10.1016/S0140-6736(24)01438-7

[11] Consider the addition of Bevacizumab and Pembrolizumab to chemotherapy for persistent recurrent or metastatic carcinoma of the cervix. Refer to Ontario Health (Cancer Care Ontario) for appropriate **Bevacizumab Eligibility Form and Pembrolizumab Eligibility Form.**

[12] Monk BJ, Colombo N, Tewari KS, Dubot C, Caceres V, Hasegawa K, et al. First-line pembrolizumab + chemotherapy versus placebo + chemotherapy for persistent, recurrent, or metastatic cervical cancer: final overall survival results of KEYNOTE-826. JCO. 2023; 41(36). DOI: https://doi.org/10.1200/JCO.23.00914

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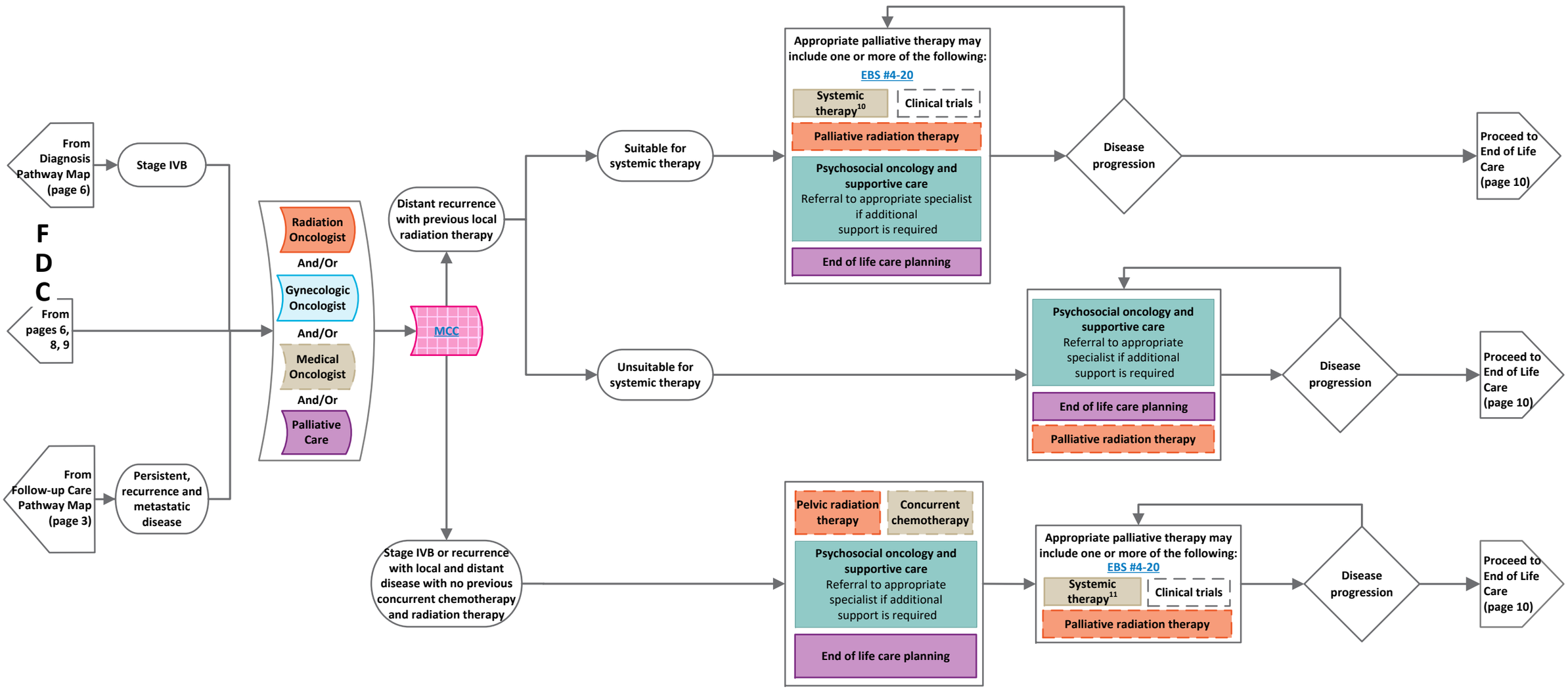

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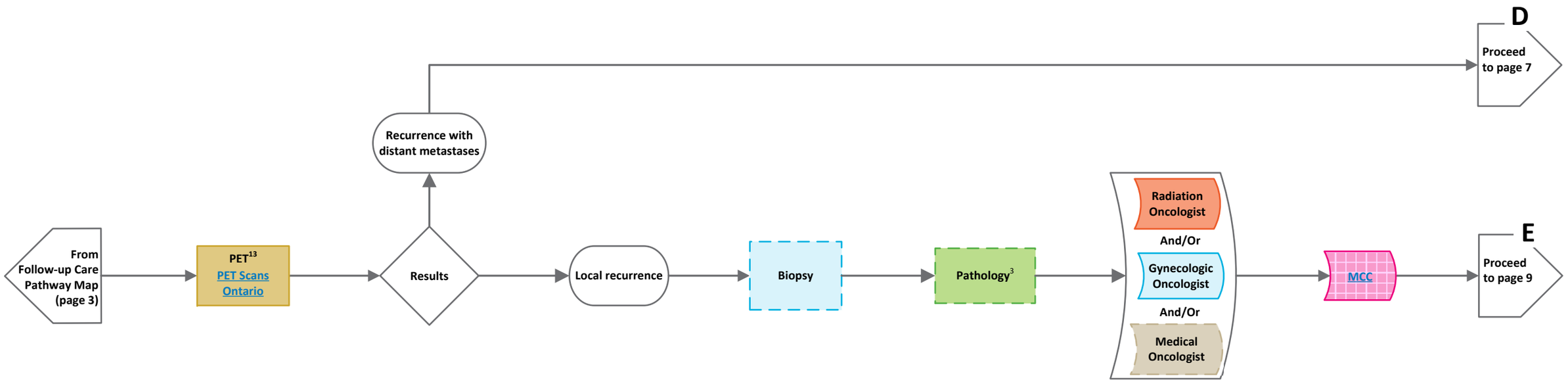

[3] Pathologists with a specialty or special interest in gynecologic pathology.

[13] PET scan should be ordered if it is used to a) guide biopsy/establish a diagnosis of recurrence after a failed attempt at CT/US-guided biopsy, or b) exclude extra-pelvic metastatic disease prior to salvage therapy.

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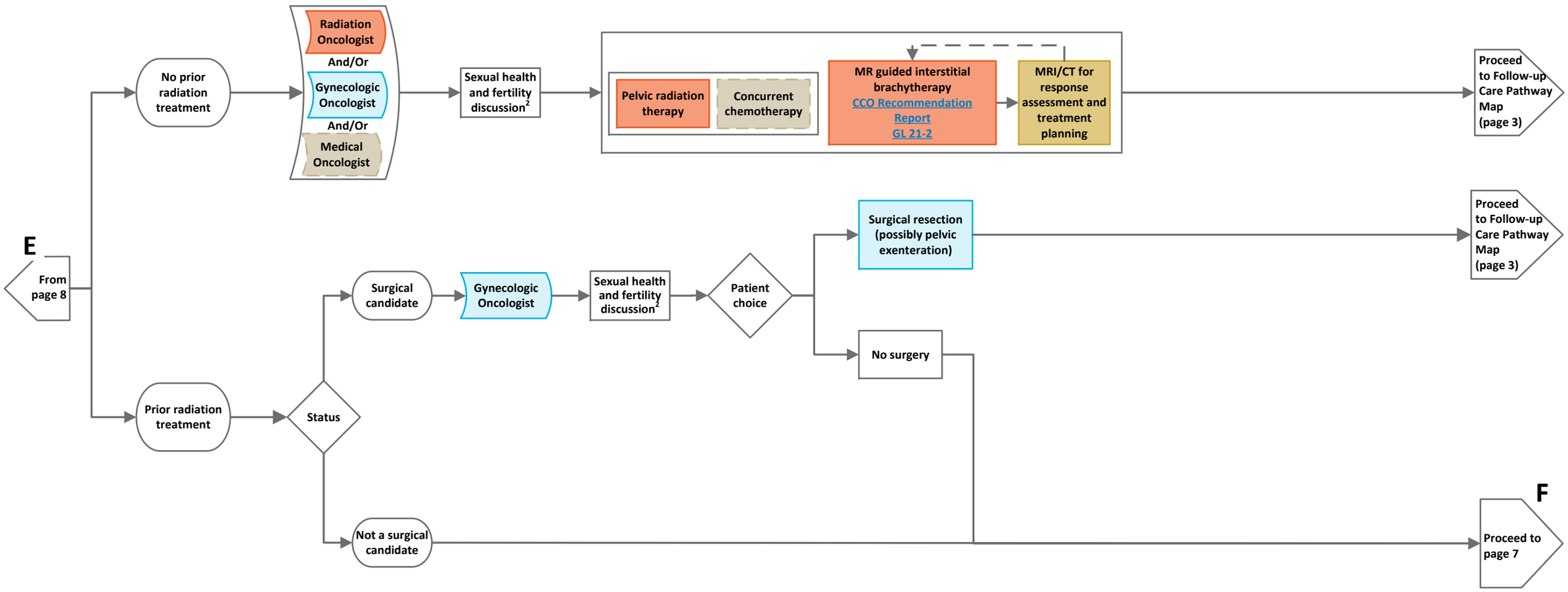

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Pathway Map Target Population:

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
  OR
- Palliative Performance Scale (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 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

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Patient Death

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