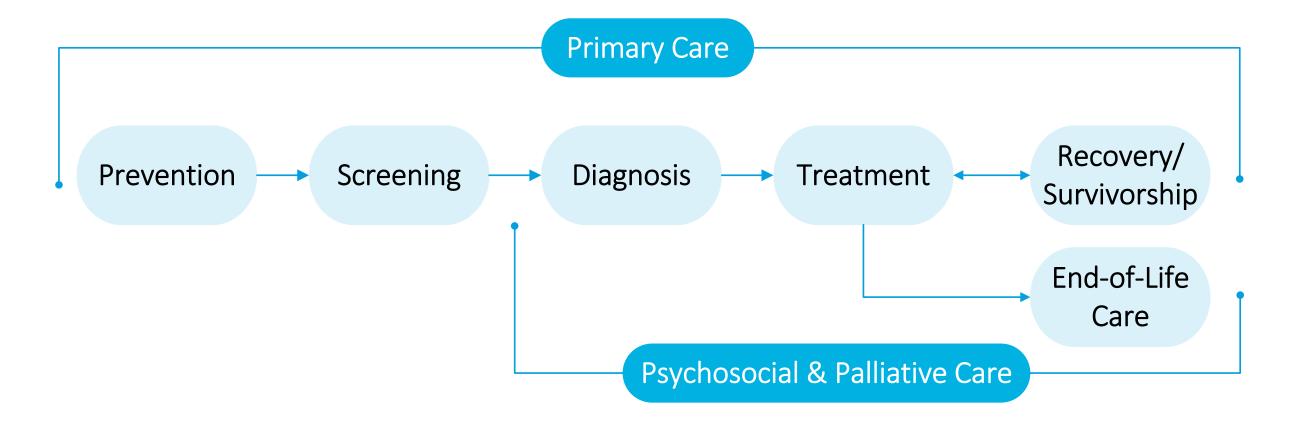
Thymic Cancer Treatment Pathway Map Version 2025.03



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Target Population

Adult patients presenting with thymic epithelial tumours, including thymoma, thymic carcinoma, and thymic neuroendocrine tumours (NETs).

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, 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-Centred 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 <u>EBS #19-3</u>.*

Pathway Map Legend

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

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. Ontario Health (Cancer Care Ontario) 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.

^{*} 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.

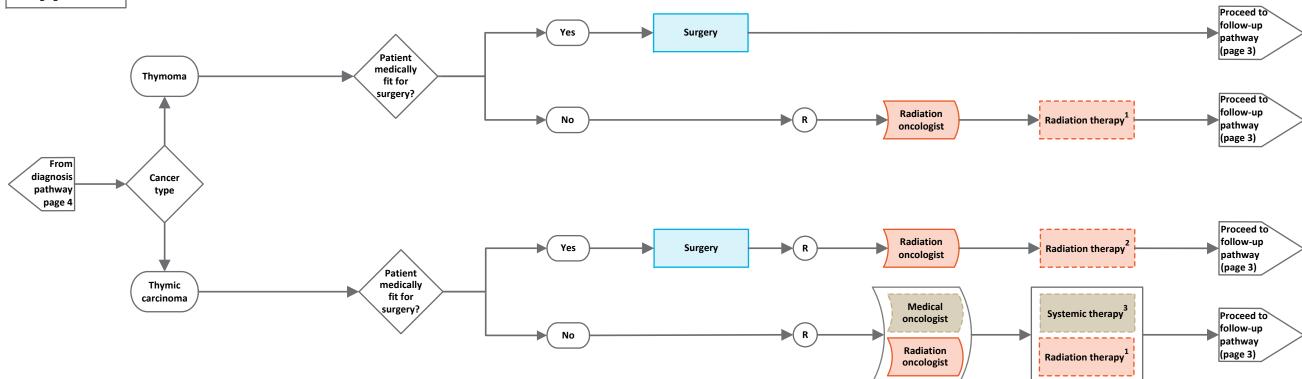
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

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

Stage I

Stage I T1a, b | N0 | M0

Thymoma/Thymic Carcinoma TNM Staging 8th edition



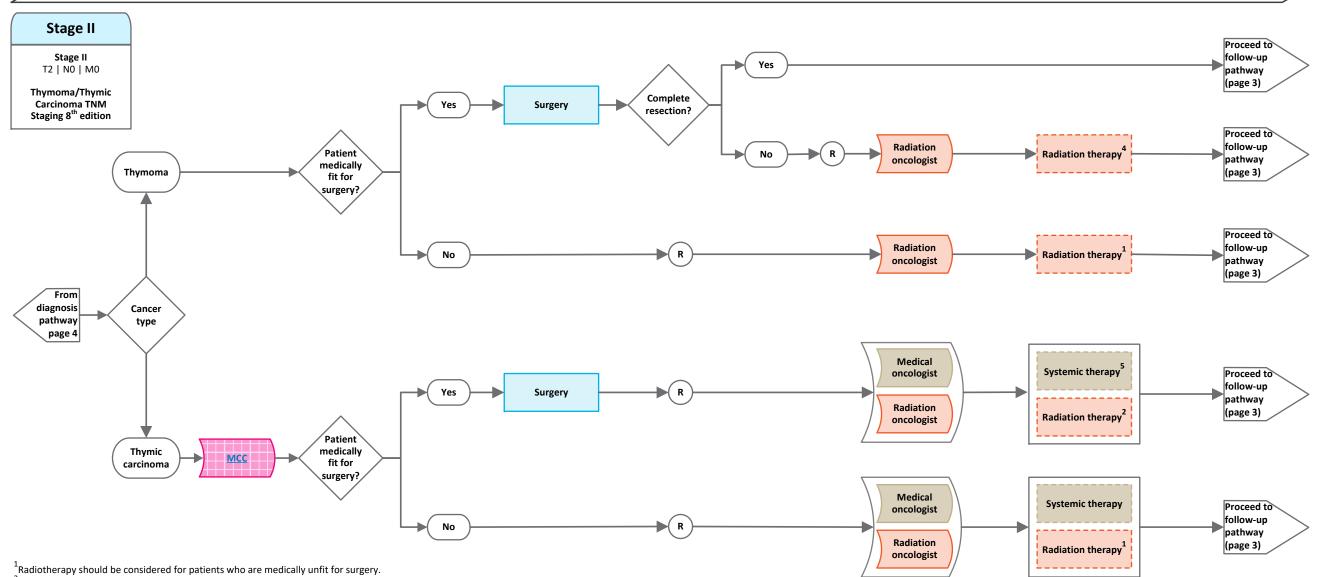
¹Radiotherapy should be considered for patients who are medically unfit for surgery.

² For patients with thymic carcinoma, postoperative radiotherapy should be considered. Possible harms verses benefits need to be discussed with patients.

³There is insufficient evidence regarding the role of chemotherapy.

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²For patients with thymic carcinoma, postoperative radiotherapy should be considered. Possible harms verses benefits need to be discussed with patients.

⁴ For patients with stage II thymoma, routine postoperative radiotherapy is currently not recommended. However, postoperative radiotherapy should be considered in patients with incomplete resection or positive margins.

⁵Adjuvant chemotherapy is not routinely recommended

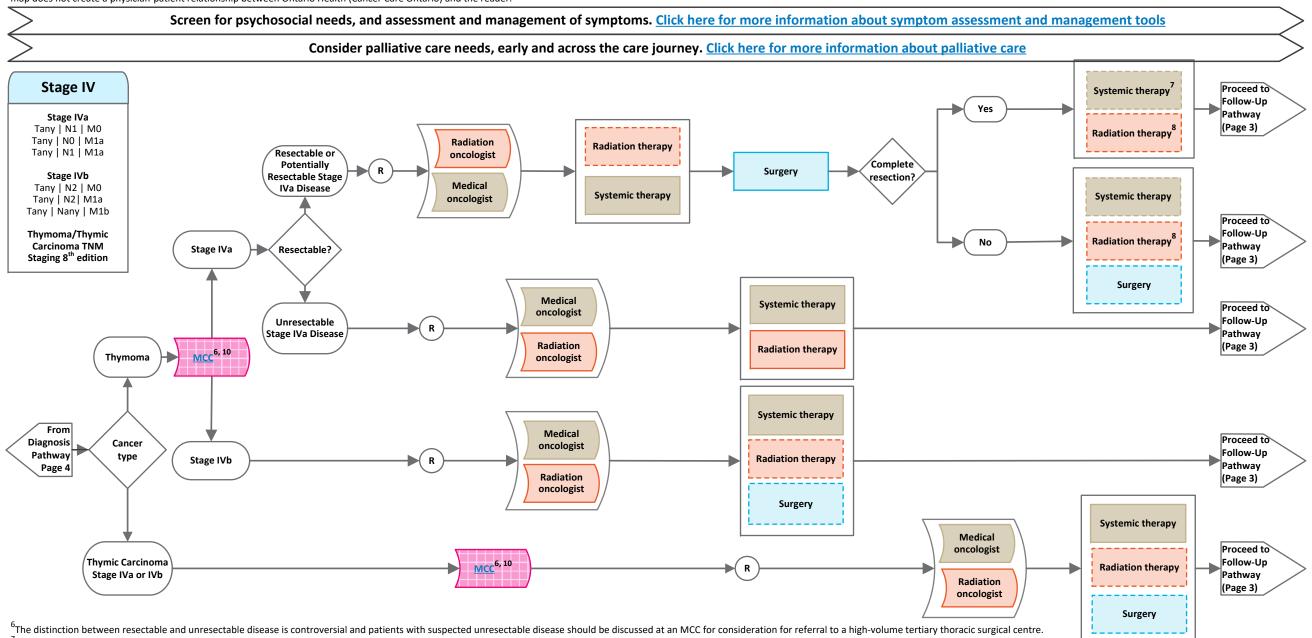
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools Consider palliative care needs, early and across the care journey. Click here for more information about palliative care Stage III Systemic therapy Proceed to follow-up Yes Stage III pathway T3, 4 | N0 | M0 (page 3) Medical Radiation therapy Systemic therapy Potentially oncologist Thymoma/Thymic Complete resectable Surgery Carcinoma TNM resection? stage III Staging 8th edition Radiation disease Radiation therapy oncologist Systemic therapy Proceed to follow-up No pathway (page 3) Radiation therapy Resectable? Thymoma Yes Medical Systemic therapy oncologist Proceed to Unresectable follow-up stage III Responds No Systemic therapy pathway disease Radiation (page 3) Radiation therapy oncologist diagnosis pathway type page 4 Medical Systemic therapy Systemic therapy Proceed to Potentially oncologist resectable follow-up Surgery stage III pathway Radiation disease (page 3) Radiation therapy Radiation therapy oncologist Thymic MCC⁶ Resectable? carcinoma Medical Systemic therapy oncologist Proceed to Unresectable follow-up stage III Responds Systemic therapy pathway disease Radiation (page 3) Radiation therapy oncologist

⁶The distinction between resectable and unresectable disease is controversial and patients with suspected unresectable disease should be discussed at an MCC for consideration for referral to a high-volume tertiary thoracic surgical centre.

Adjuvant chemotherapy is not routinely recommended and should not be offered without discussion at MCC.

Postoperative radiotherapy can be considered if the patient has not received neoadjuvant radiotherapy and there are concerns about clear resection margins.

⁹Adjuvant systemic therapy should only be considered in patients with thymic carcinoma that did not receive neoadjuvant systemic therapy and based upon MCC recommendation.



⁷Adjuvant chemotherapy is not routinely recommended and should not be offered without discussion at MCC.

⁸Postoperative radiotherapy can be considered if the patient has not received neoadjuvant radiotherapy and there are concerns about clear resection margins.

¹⁰Treatment decisions should reflect the extent and location of metastatic disease. These patients should be discussed at an MCC, and treatment goals reviewed

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Stage I and II Stage I T1a, b | N0 | M0

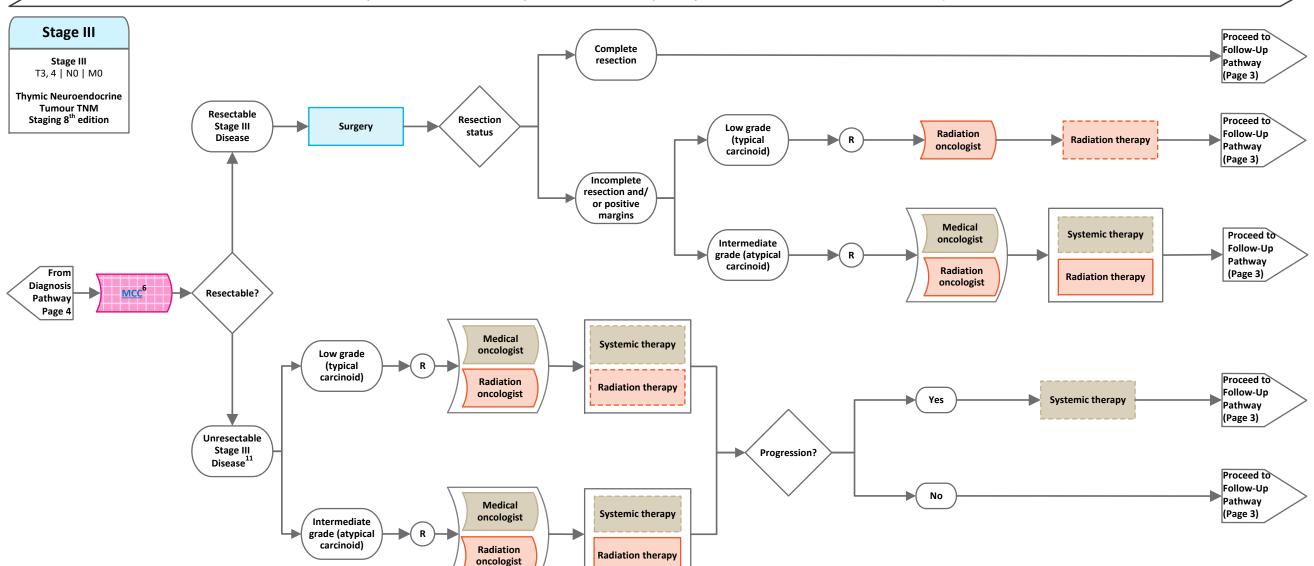
Stage II

T2 | N0 | M0 **Thymic Neuroendocrine** Proceed to Tumour TNM Follow-Up Yes Staging 8th edition Pathway (Page 3) From Diagnosis Complete Surgery Pathway resection? Page 4 Proceed to Radiation Follow-Up Radiation therapy oncologist Pathway (Page 3)

⁸Postoperative radiotherapy can be considered if the patient has not received neoadjuvant radiotherapy and there are concerns about clear resection margins.

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The distinction between resectable and unresectable disease is controversial and patients with suspected unresectable disease should be discussed at an MCC for consideration for referral to a high-volume tertiary thoracic surgical center.

¹¹For symptom control, consider addition of focal therapy (i.e., endobronchial therapy debulking, ablation).

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Stage IV

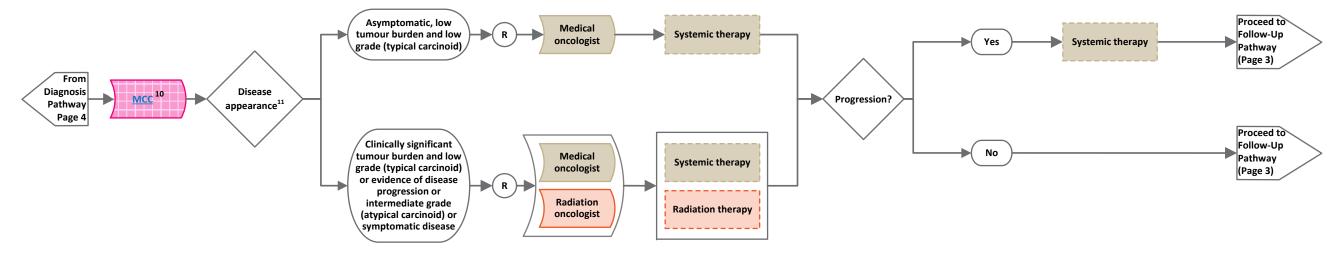
Stage IVa

Tany | N1 | M0 Tany | N0 | M1a Tany | N1 | M1a

Stage IVb

Tany | N2 | M0 Tany | N2 | M1a Tany | Nany | M1b

Thymic Neuroendocrine Tumour TNM Staging 8th edition

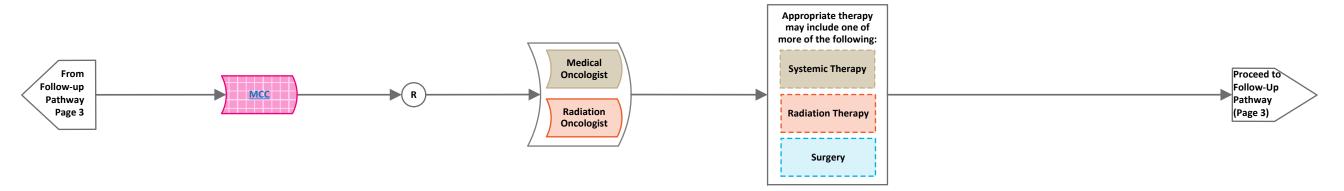


Treatment decisions should reflect the extent and location of metastatic disease. These patients should be discussed at an MCC, and treatment goals reviewed.

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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 <u>end of life</u>, palliative care should be initiated much earlier in the illness trajectory.

Triggers that suggest patients are nearing the last few months and weeks of life

(PRFS) = 4

Palliative

Declining

ability

OR

Scale (PPS) ≤ 50

status/functional

Performance

performance



Screen, Assess,

Plan, Manage and Follow Up

End of Life Care Eastern planning and Cooperative implementation **Oncology Group** Collaboration and (ECOG) consultation Performance between specialist-Status/Patientlevel care teams ECOG/Patient and primary care Reported teams **Functional Status**



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

Thymic Cancers Treatment Pathway Map

End of Life Care (continued)

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	At the time of death:	
Patient 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 	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
	 □ Initiate grief care for family members at risk for complicated grief □ Encourage the bereaved to make an appointment with 	

opportunities for debriefing of care team, including volunteers

Provide

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