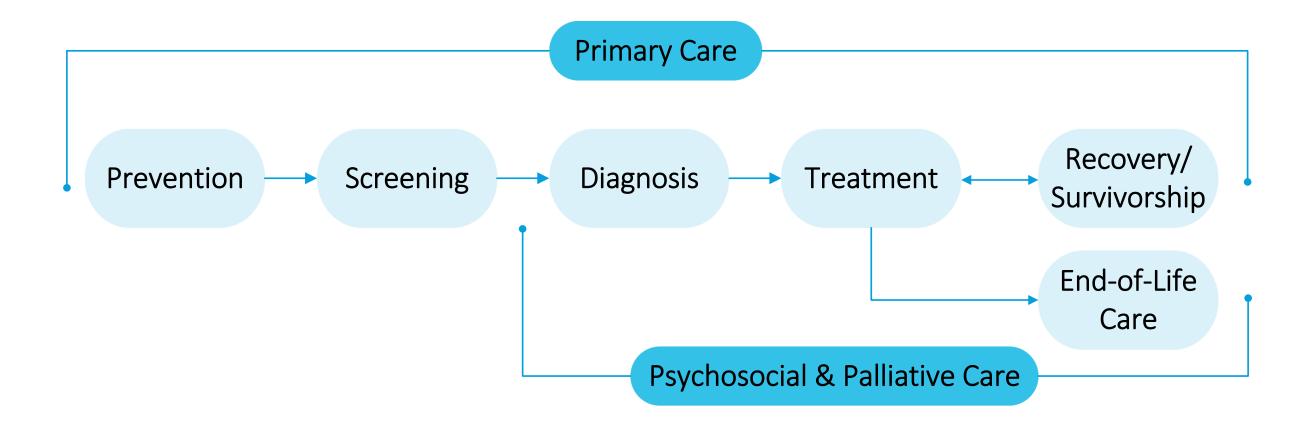
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Target Population

Patients with a confirmed breast cancer diagnosis who have undergone the recommended diagnostic and staging procedures outlined in the **Breast Cancer Screening and Diagnosis Pathway Map**.

Pathway Map Considerations

- Consider recommendation for exercise. For more information visit Exercise for people with cancer.
- For principles of synoptic pathology reporting and biomarker testing in breast cancer, see CAP guidelines and protocols www.cap.org.
- 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, nurse practitioners, and emergency physicians.
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on MCCs, 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.
- 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
- 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>.*
- 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 health care providers will provide the care, and the patient's overall approach to care.

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	\bigcirc or \bigcirc	Off page reference		
	Radiology	R	Ref erral		
	Multidisciplinary Cancer Conference (MCC)				
	Genetics				
	Psychosocial Oncology (P	SO)			

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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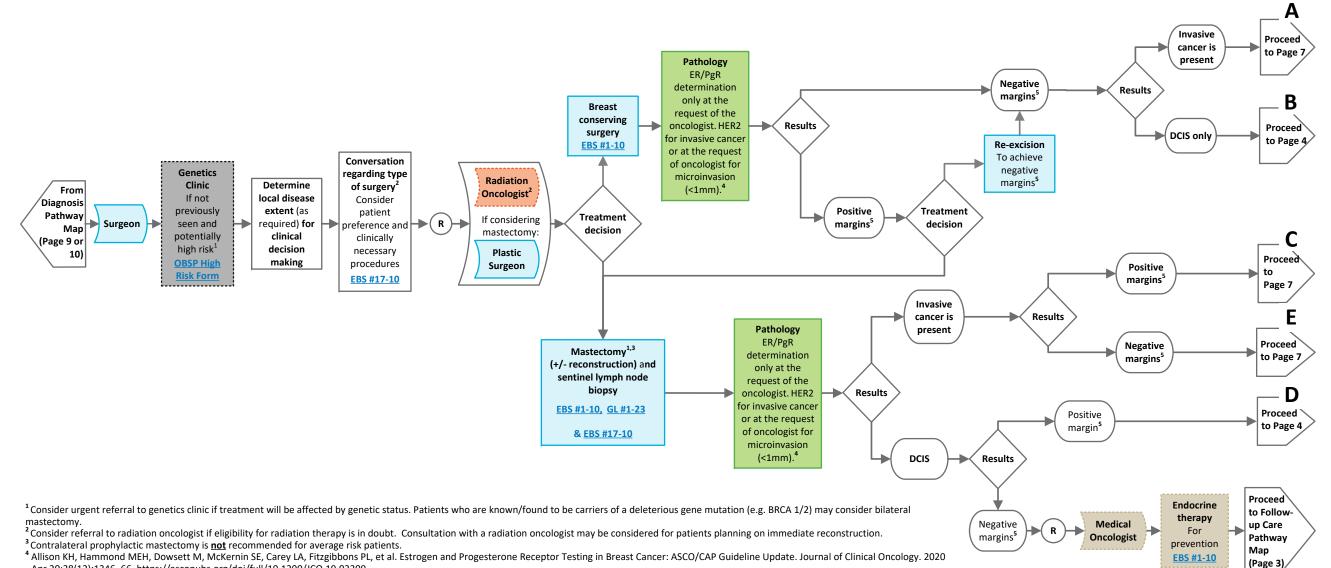
While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an "as-is" basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information's quality, accuracy, currency, completeness, or reliability.

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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 #19-3</u> 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



Apr 20;38(12):1346–66. https://ascopubs.org/doi/full/10.1200/JCO.19.02309

Spositive margins are defined as ink on tumour and the optimal negative margin width is > 2 mm. Morrow M, Van Zee KJ, Solin LJ, Houssami N, Chavez-MacGregor M, Harris JR, et al. Society of Surgical Oncology–

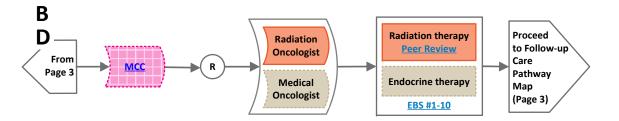
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Ductal Carcinoma In Situ (contd)

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Invasive Breast Cancer: Assessment for Operability and Neoadjuvant Therapy

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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 Candidate for primary surgical management Proceed to Page 6 Candidate for Reevaluation of pathology Operable neoadjuvant Examination of pathology systemic report on core needle therapy? biopsy results **Genetics Clinic Biomarkers** Clinical From If not previously ER/PgR and HER2 if not Medical suspicion of Diagnosis seen and previously done Oncologist distant Disease Pathway Surgeon NO metastases or status Map (Page risk1 **Determine clinical stage** tage III cancer 9 or 10) **OBSP High Risk GL 1-14** Candidate for neoadjuvant Proceed Form If clinically node positive: systemic therapy. HER2+ or TN: Ultrasound-guided lymph T2 or greater or node biopsy to confirm YES. T1 on a case-by-case basis: nodal status Clinical ER+, HER2-: Consider further nodal GL #1-23 T2N1 on a case-by-case basis; staging status T3 and any biomarker profile; Proceed Negative N2 and any biomarker profile if not to Page 9 bulky or matted: Consider breast-to-tumour ratio if Consider the following to breast conserving surgery is desired exclude metastatic disease For stage IIb or stage III Inoperable invasive ductal cancer T4 including Proceed PET inflammatory breast to Page 11 cancer; N2 - bulky or Suspicion of metastasis matted; N3. less than stage IIb No distant metastases Abdominal and Results chest imaging Proceed Bone scan Distant metastases to Page 12 (Stage IV) GL 1-14

¹ Consider urgent referral to genetics clinic if treatment will be affected by genetic status. Patients who are known/found to be carriers of a deleterious gene mutation (e.g. BRCA 1/2) may consider bilateral mastectomy.

⁶ Wolff AC, Hammond MEH, Hicks DG, Dowsett M, McShane LM, Allison KH, et al. Recommendations for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer: American Society of Clinical Oncology/College of American Pathologists Clinical Practice Guideline Update. Journal of Clinical Oncology, 2013 Nov;31(31):3997–4013. https://pubmed.ncbi.nlm.nih.gov/24101045/

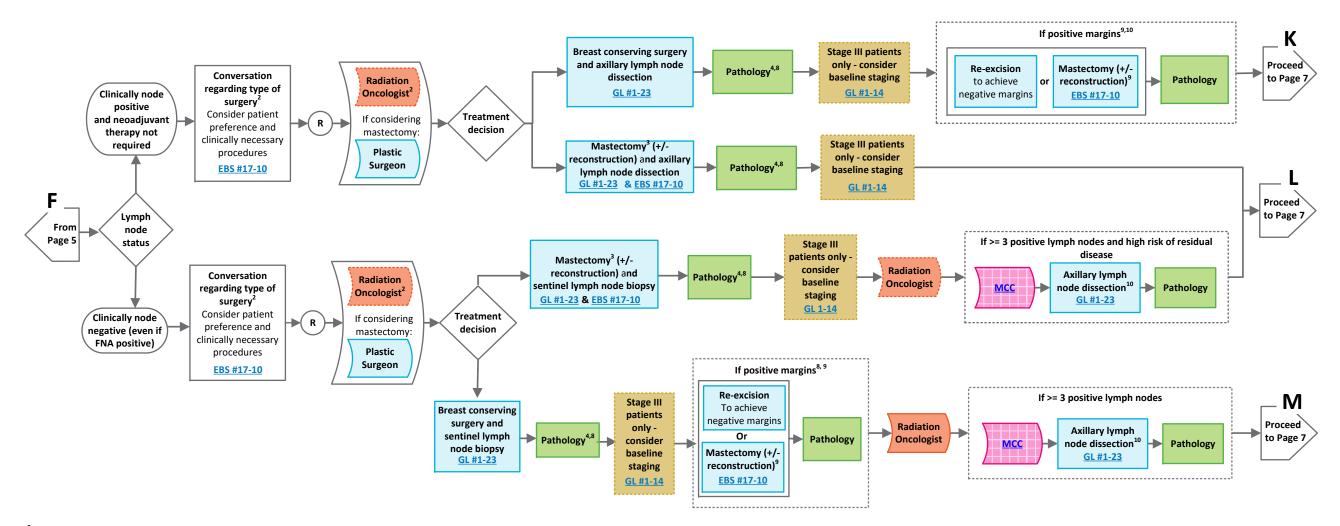
⁷ Gandhi S, Brackstone M, Hong NJL, Grenier D, Donovan E, Lu Fang-I, et al. A Canadian national guideline on the neoadjuvant treatment of invasive breast cancer, including patient assessment, systemic therapy, and local management principles. Breast Cancer Research and Treatment. 2022 Feb 28;193(1):1–20. https://link.springer.com/article/10.1007/s10549-022-06522-6

Operable Invasive Breast Cancer: Candidates for Primary Surgical Management

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²Consider referral to radiation oncologist if eligibility for radiation therapy is in doubt. Consultation with a radiation oncologist may be considered for patients planning on immediate reconstruction.

³Contralateral prophylactic mastectomy is **not** recommended for average risk people.

Allison KH, Hammond MEH, Dowsett M, McKernin SE, Carev LA, Fitzgibbons PL, et al. Estrogen and Progesterone Receptor Testing in Breast Cancer: ASCO/CAP Guideline Update. Journal of Clinical Oncology. 2020 Apr 20;38(12):1346-66. https://ascopubs.org/doi/full/10.1200/JCO.19.02309

⁸ If no cancer in surgical specimen (e.g. very small tumours, <1cm) refer to core biopsy pathology including biomarker testing.

⁹ Negative margins are defined as no ink on tumor [no cancer cells adjacent to any inked edge/surface of the specimen] and positive margins are defined as ink on tumour. Buchholz TA, Somerfield MR, Griggs JJ, El-Eid S, Hammond MEH, Lyman GH, et al. Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Stage I and II Invasive Breast Cancer: American Society of Clinical Oncology Endorsement of the Society of Surgical Oncology/American Society for Radiation Oncology Consensus Guideline. Journal of Clinical Oncology. 2014 May 10;32(14):1502–6. https://ascopubs.org/doi/full/10.1200/JCO.2014.55.1572

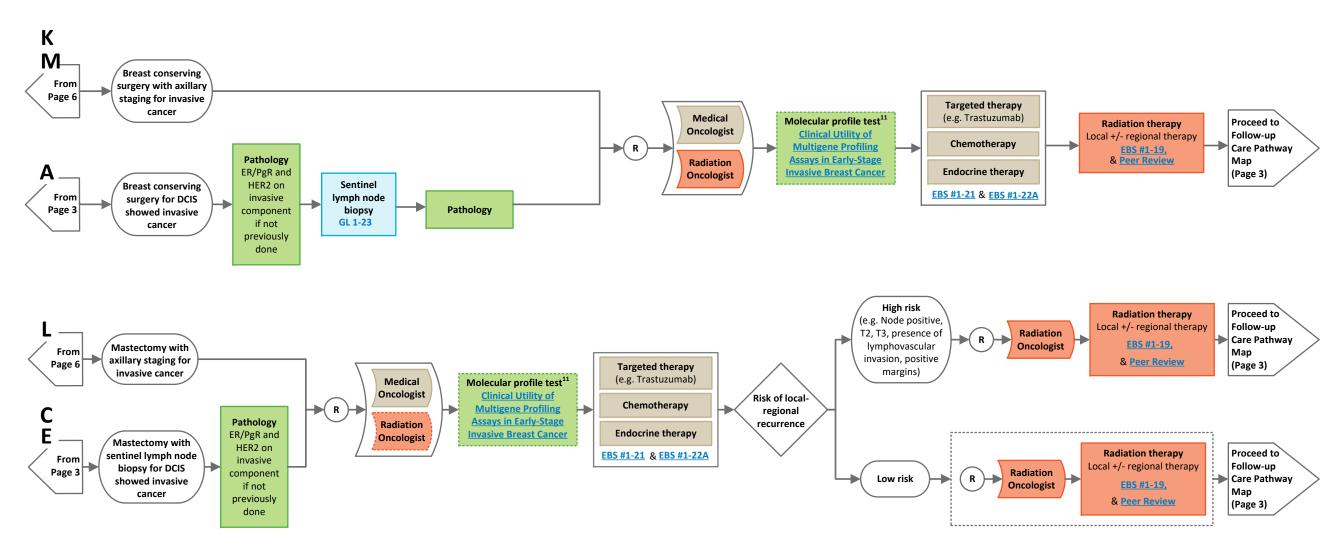
¹⁰ May defer re-excision, mastectomy and axillary lymph node dissection until after systemic therapy if high risk of systemic recurrence

Adjuvant Treatment Following Primary Surgical Management

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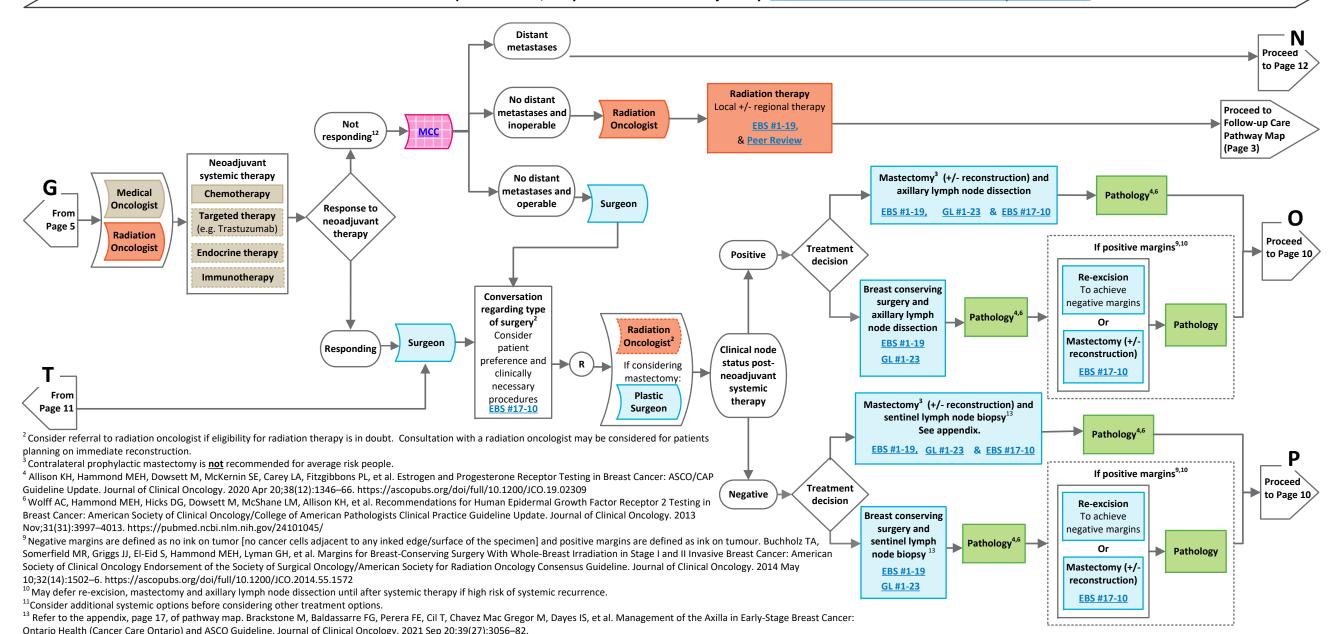


¹¹Candidates for molecular profile tests are patients with ER positive, HER2 negative, and lymph-node negative early-stage invasive breast cancer in whom the decision for chemotherapy is unclear.

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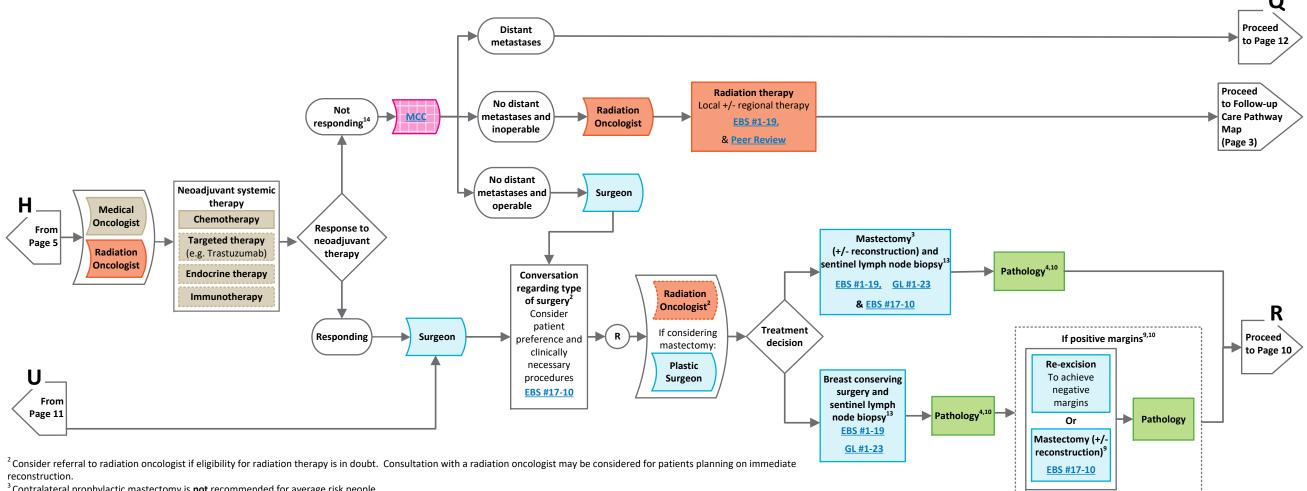


Operable Invasive Breast Cancer: Node Negative Candidates for Neoadjuvant Therapy

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³ Contralateral prophylactic mastectomy is **not** recommended for average risk people.

⁴ Allison KH, Hammond MEH, Dowsett M, McKernin SE, Carey LA, Fitzgibbons PL, et al. Estrogen and Progesterone Receptor Testing in Breast Cancer: ASCO/CAP Guideline Update. Journal of Clinical Oncology, 2020 Apr 20:38(12):1346–66. https://ascopubs.org/doi/full/10.1200/JCO.19.02309

⁹ Negative margins are defined as no ink on tumor [no cancer cells adjacent to any inked edge/surface of the specimen] and positive margins are defined as ink on tumour. Buchholz TA, Somerfield MR, Griggs JJ, El-Eid S, Hammond MEH, Lyman GH, et al. Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Stage I and II Invasive Breast Cancer: American Society of Clinical Oncology Endorsement of the Society for Radiation Oncology Consensus Guideline. Journal of Clinical Oncology. 2014 May 10;32(14):1502-6. https://ascopubs.org/ doi/full/10.1200/JCO.2014.55.1572

¹⁰ May defer re-excision, mastectomy and axillary lymph node dissection until after systemic therapy if high risk of systemic recurrence.

¹³ Refer to the appendix, page 17. of pathway map. Brackstone M, Baldassarre FG, Perera FE, Cil T, Chavez Mac Gregor M, Dayes IS, et al. Management of the Axilla in Early-Stage Breast Cancer: Ontario Health (Cancer Care Ontario) and ASCO Guideline. Journal of Clinical Oncology. 2021 Sep

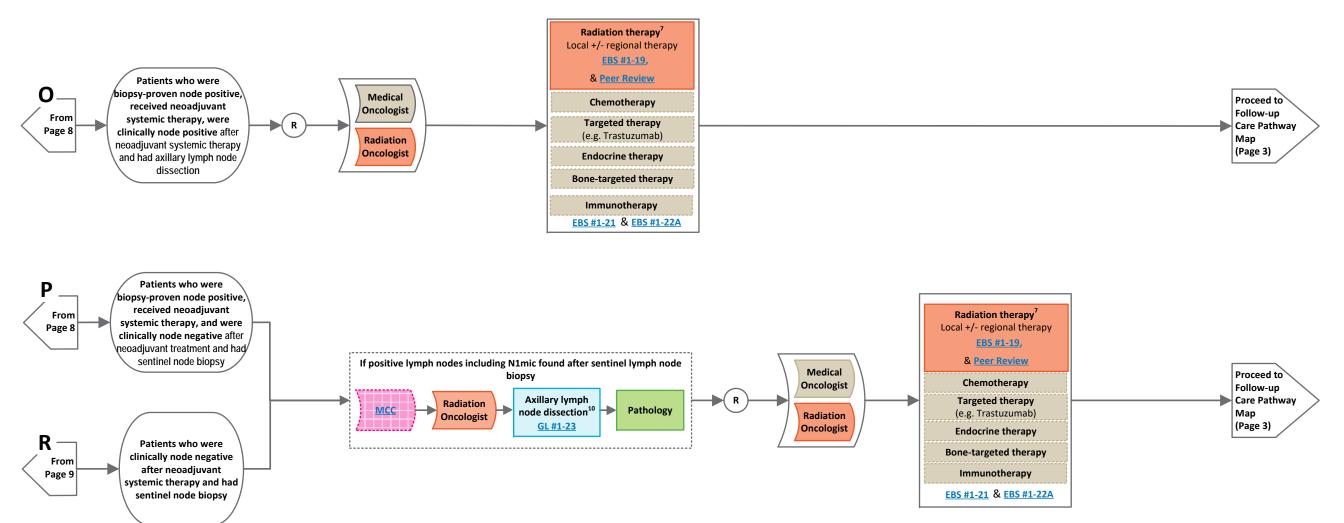
¹⁴Consider additional systemic options before considering other treatment options.

Operable Invasive Breast Cancer: Candidates for Neoadjuvant Therapy (contd)

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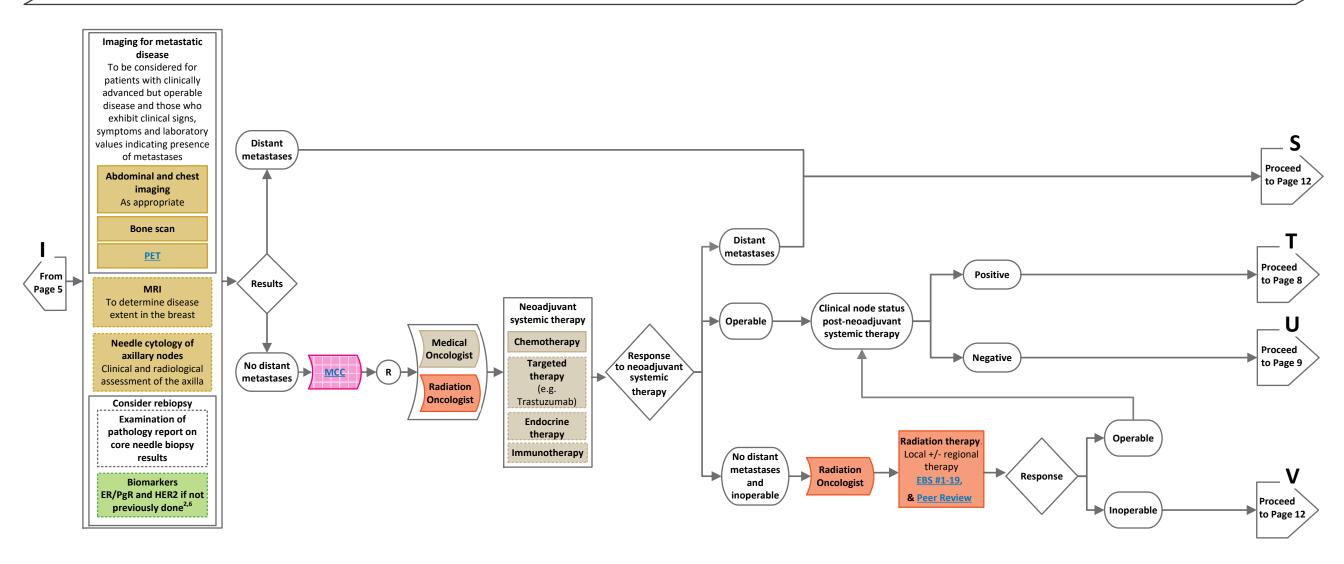
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⁷ Gandhi S, Brackstone M, Hong NJL, Grenier D, Donovan E, Lu Fang-I, et al. A Canadian national guideline on the neoadjuvant treatment of invasive breast cancer, including patient assessment, systemic therapy, and local management principles. Breast Cancer Research and Treatment. 2022 Feb 28;193(1):1–20.

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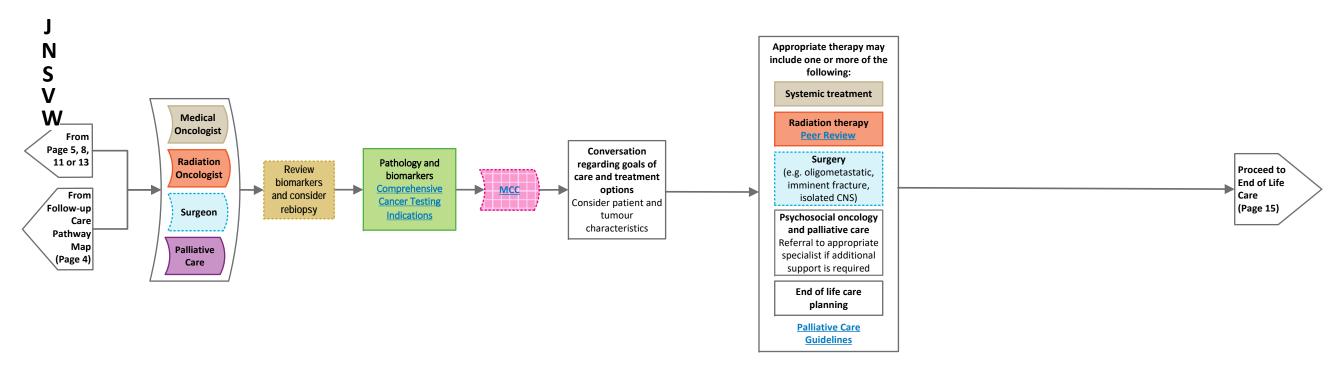
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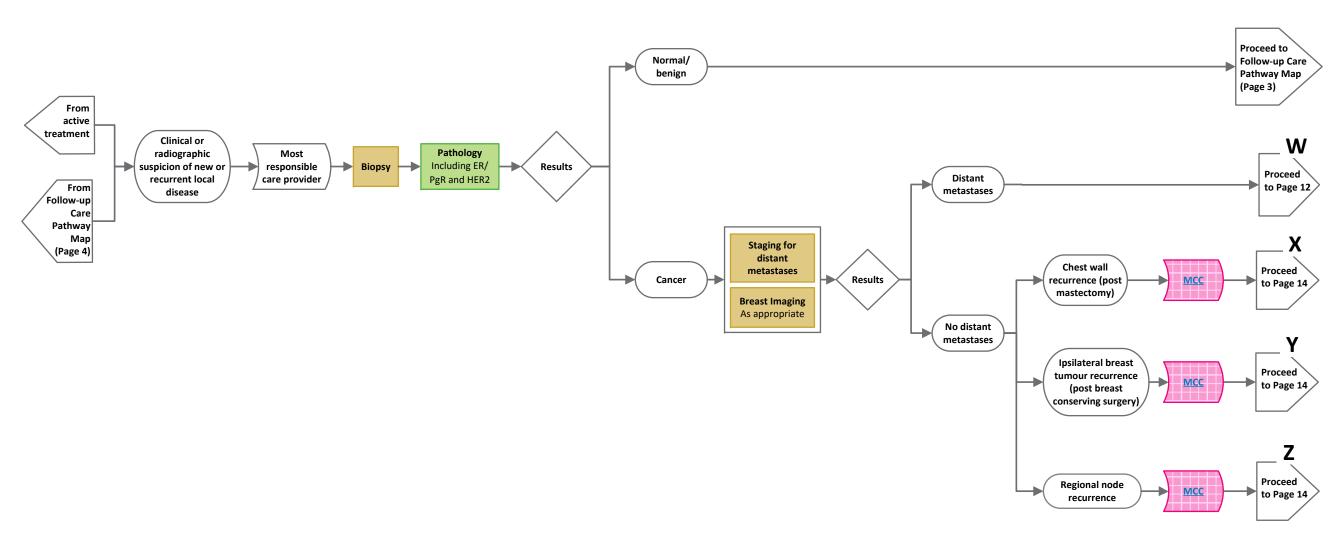
²Consider referral to radiation oncologist if eligibility for radiation therapy is in doubt. Consultation with a radiation oncologist may be considered for patients planning on immediate reconstruction.

⁶ Wolff AC, Hammond MEH, Hicks DG, Dowsett M, McShane LM, Allison KH, et al. Recommendations for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer: American Society of Clinical Oncology/College of American Pathologists Clinical Practice Guideline Update. Journal of Clinical Oncology. 2013 Nov;31(31):3997–4013. https://pubmed.ncbi.nlm.nih.gov/24101045/

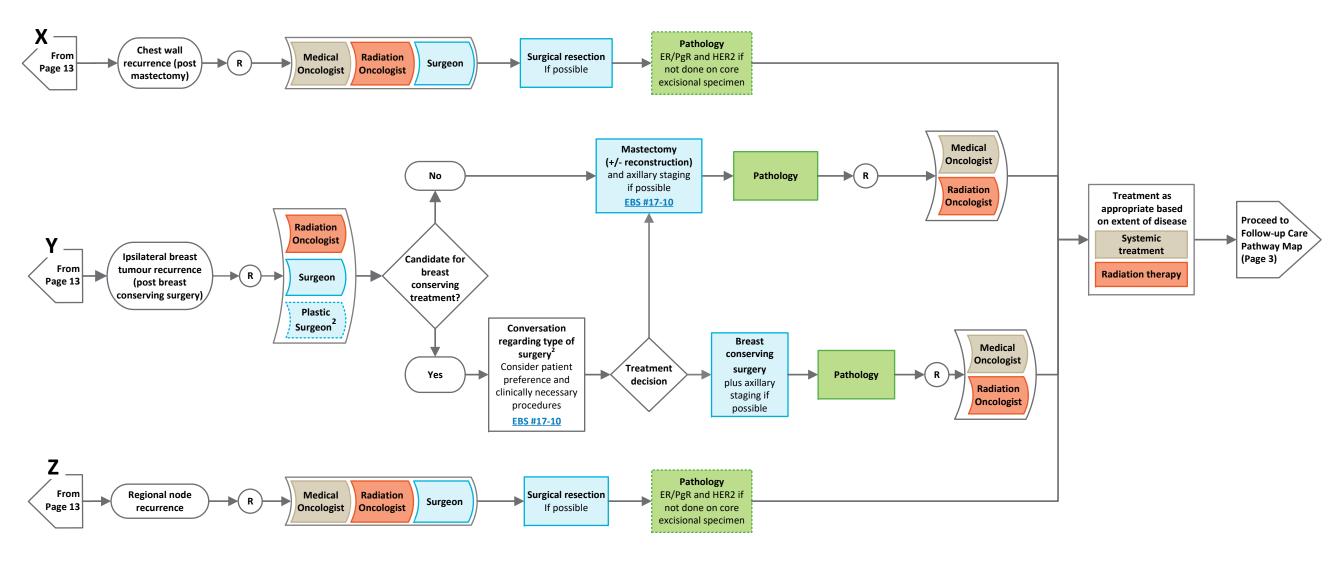
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End of Life Care

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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 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

- ECOG/Patient-ECOG/PRFS = 4 OR
- 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 specialistlevel 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

End of Life Care (contd)

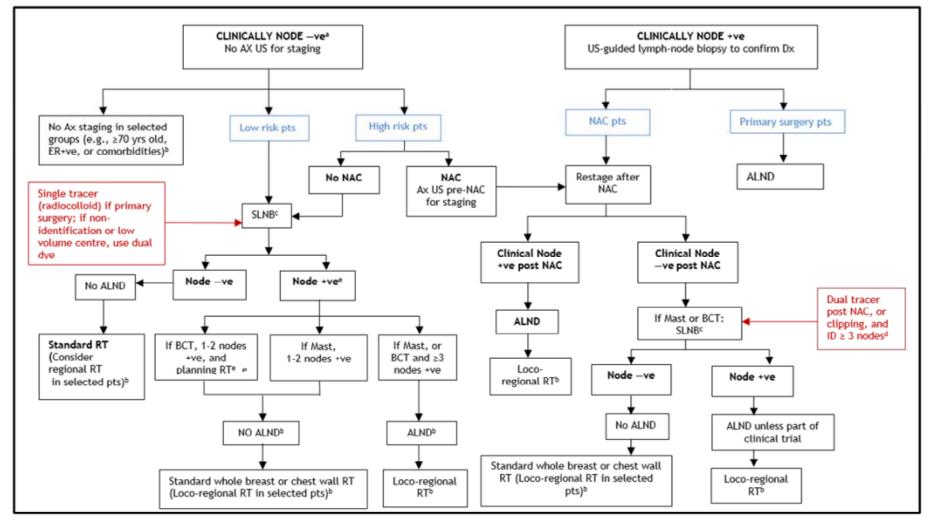
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Patient Death	t the time of death: Pronouncement of death Completion of death certificate Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death 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 Offer psychoeducation and/or Screen for complicated and absincluding children) Consider referral of bereaved to appropriate local resources counselor, hospice and other on severity of grief	Provious for counseling to the bereaved abnormal grief (family members, debrived family member(s) and children	ide ortunities for iefing of care n, including nteers
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a Refers to all patients with no palpable axillary nodes on physical examination, including those who may have had an ultrasound that was equivocal, abnormal, or even biopsy-proven positive.

Allison KH, Hammond MEH, Dowsett M, McKernin SE, Carey LA, Fitzgibbons PL, et al. Estrogen and Progesterone Receptor Testing in Breast Cancer: ASCO/CAP Guideline Update. Journal of Clinical Oncology. 2020 Apr 20;38(12):1346–66. https://ascopubs.org/doi/full/10.1200/JCO.19.02309

b Decision making should be made on a case-by-case basis, and include a patient centered approach, that is consider and discuss pros and cons of various options in light of patient's specific circumstances, values and preferences.

c Do not recommend SLNB before chemotherapy except in special circumstances after multidisciplinary discussion.

d Evidence supports the use of dual localizing tracer (blue dye and radio-isotopye) and harvesting ≥3 nodes or else do ALND to minimize false negative rate; any clipped positive nodes should be localized for surgery.

e In rare circumstances (e.g., a small T1aN1) it is possible to avoid radiation (see Justification of Recommendation 3D)