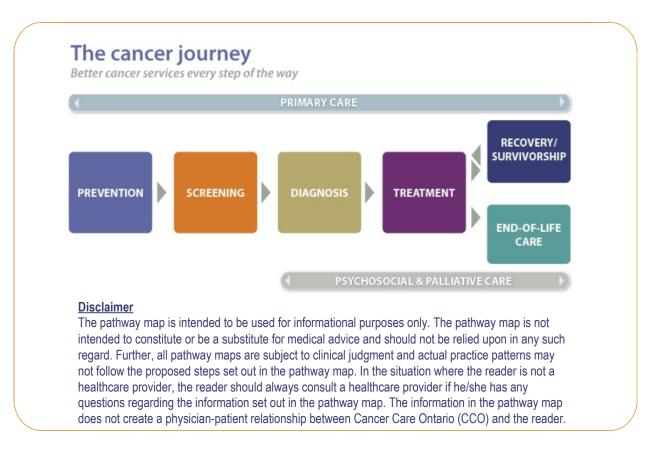


# **Endometrial Cancer Treatment & Follow-Up Pathway Map**

Disease Pathway Management Version 2017.10





# **Target Patient Population**

Women presenting with endometrial cancer

### **Pathway Map Considerations**

- For more information about the optimal organization of gynecologic oncology services in Ontario refer to EBS #4-11
- 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 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 CCO tools, resources and guidance documents.
- The term 'healthcare provider', used throughout the pathway map, includes primary care providers and specialists, midwives, nurse
  practitioners, gynecologists, emergency physicians or other healthcare providers
- For more information on Multidisciplinary Cancer Conferences visit MCC Tools
- For more information on wait time prioritization, visit: Surgery, Systemic Treatment, Radiation Treatment Wait Times prioritizations.
- 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:
  - 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

\* 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 Map Legend Shape Guide Colour Guide** Intervention Decision or assessment point **Primary Care Palliative Care** Patient (disease) characteristics Consultation with specialist Pathology Diagnostic Assessment Program (DAP) Exit pathway or Off-page reference **Gynecologic Oncology** Patient/ Provider interaction Radiation Oncology Referral **Medical Oncology** Wait time indicator time point Radiology Gynecology Line Guide Genetics Required **Multidisciplinary Cancer Conference (MCC)** ----- Possible Psychosocial Oncology (PSO)

## **Pathway Map Disclaimer**

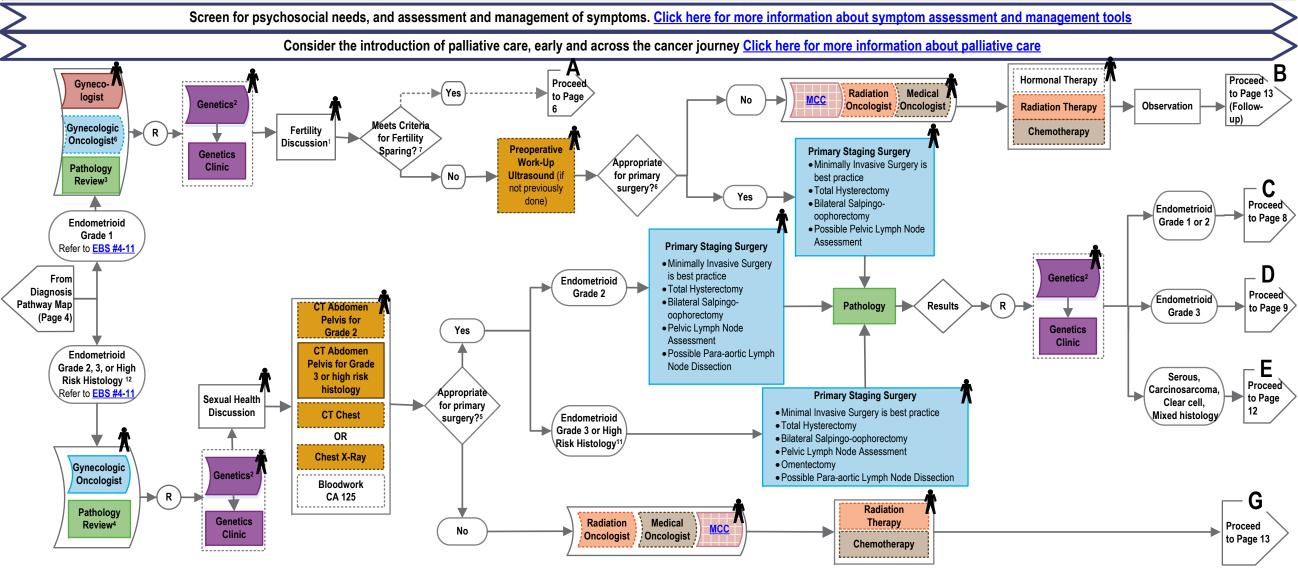
This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive

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

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Discussion to be individualized for each patient: however, may include the following: fertility options, hormone replacement therapy, referral for infertility consultation, etc.

<sup>&</sup>lt;sup>2</sup> Referral to genetics if patient meets criteria for genetic testing. See MOH Criteria - Refer to Colorectal criteria for testing

<sup>&</sup>lt;sup>3</sup> Endometrioid Grade 1: If grade I endometriod cancer diagnosed at a non-gynecologic oncology center (GOC), the pathology must be reviewed by a second pathologists must be in agreement with diagnosis of grade I endometriod cancer; otherwise, referral of patient to a GOC is necessary.

<sup>&</sup>lt;sup>4</sup>Endometriod Grade 2, 3 or High Risk Histology: Pathology review by a pathologist with an interest in gynecologic pathology at a gynecologic oncology center (GOC)

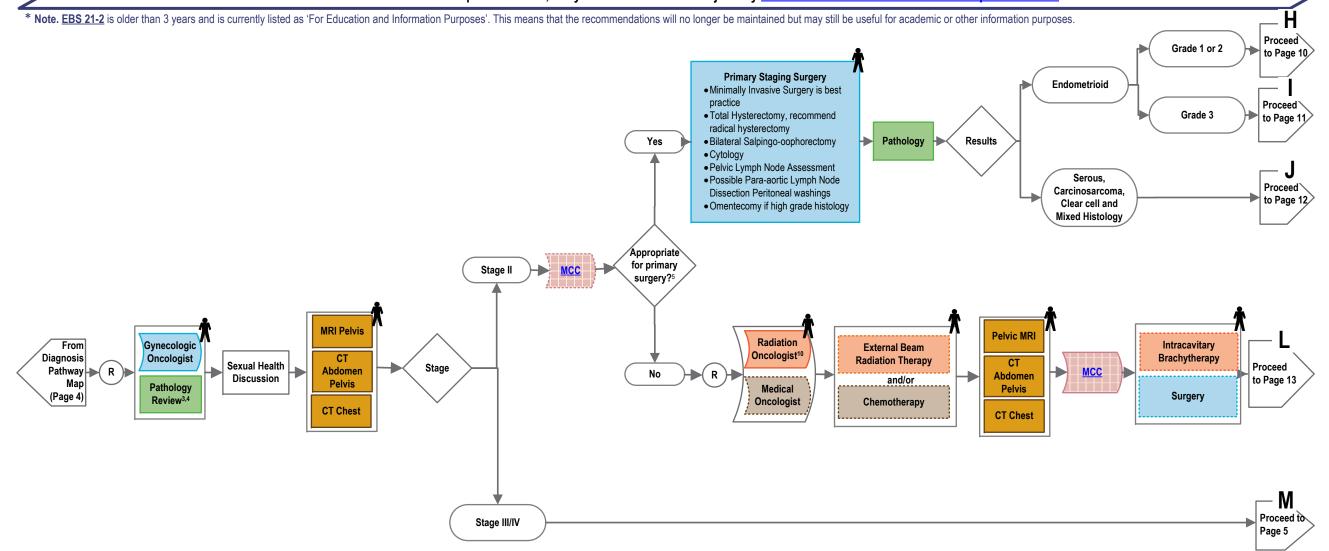
<sup>&</sup>lt;sup>5</sup> The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities

<sup>6</sup> Referral to gynecologist oncologist is optional for patients with grade 1 disease, however patients who are unfit for surgery or have a clinically enlarged cervix should be referred to a gynecologist oncologist

<sup>&</sup>lt;sup>7</sup> Patients should undergo counseling that fertility sparing is for highly selected and motivated patients who meet strict criteria for progestin therapy include: 1) Grade 1 endometrioid adenocarcinoma, 2) no myometrial invasion on MRI, 3) no metastatic disease, 4) no contraindications to progesterone therapy, 5) desire for future fertility.

<sup>&</sup>lt;sup>11</sup> High risk histology: serous, clear cell, carcinosarcoma, undifferentiated, mixed high grade

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



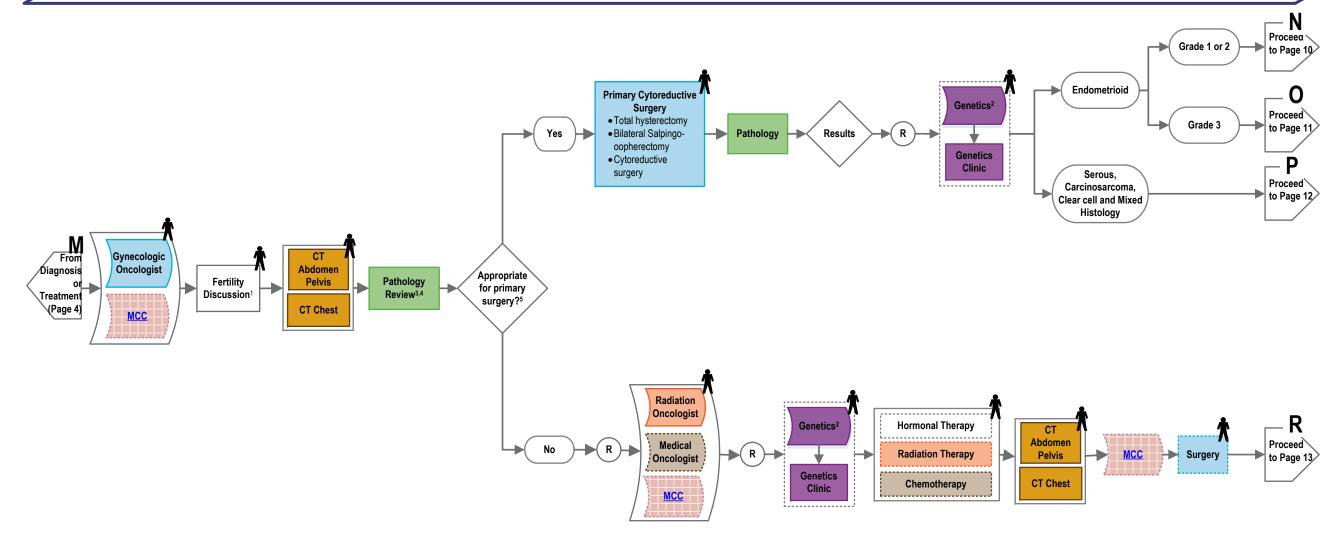
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<sup>&</sup>lt;sup>10</sup> Consider referral to a radiation centre with intracavitary brachytherapy cases ≥ 10 per year EBS 4-11; EBS 21-2\*

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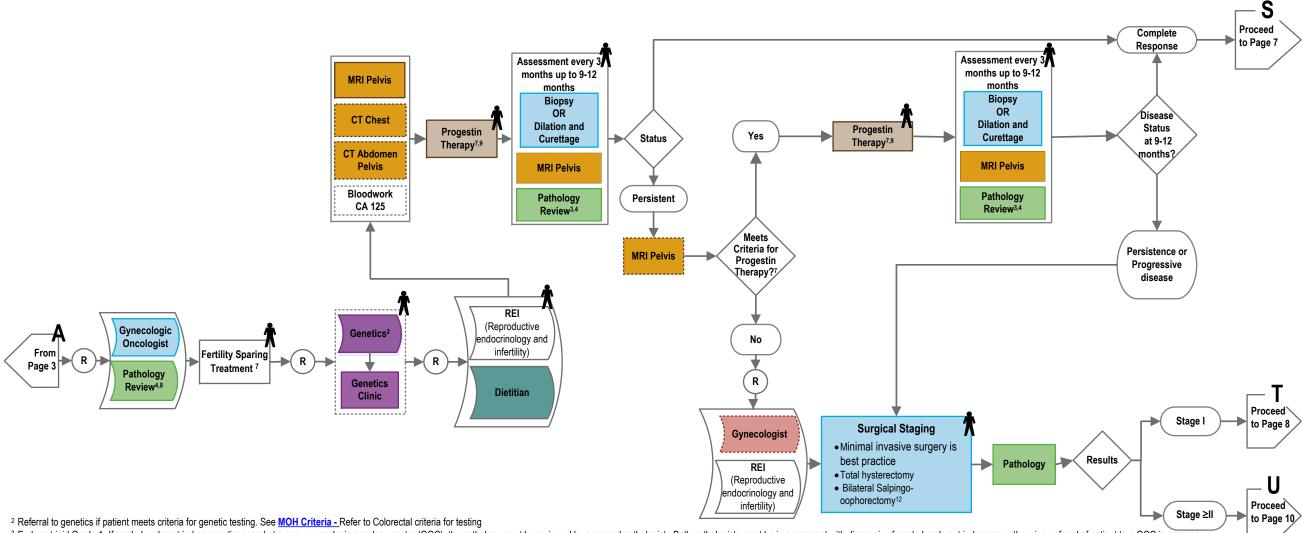
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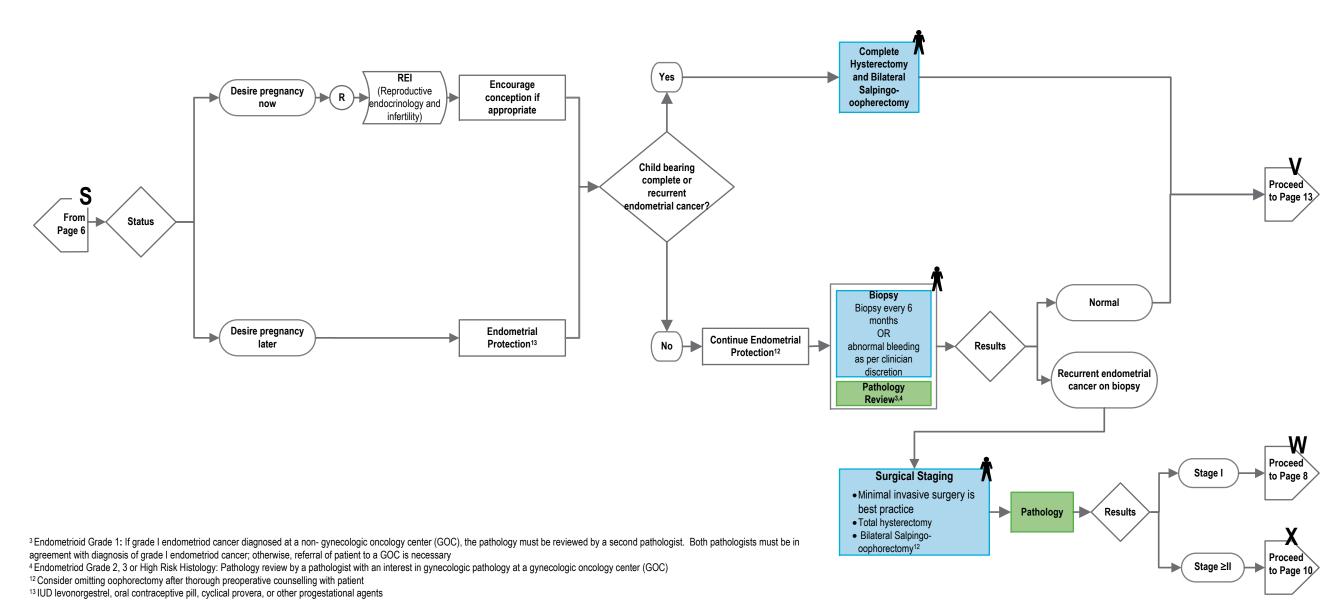
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<sup>8</sup> Consider requesting IHC for mismatch repair

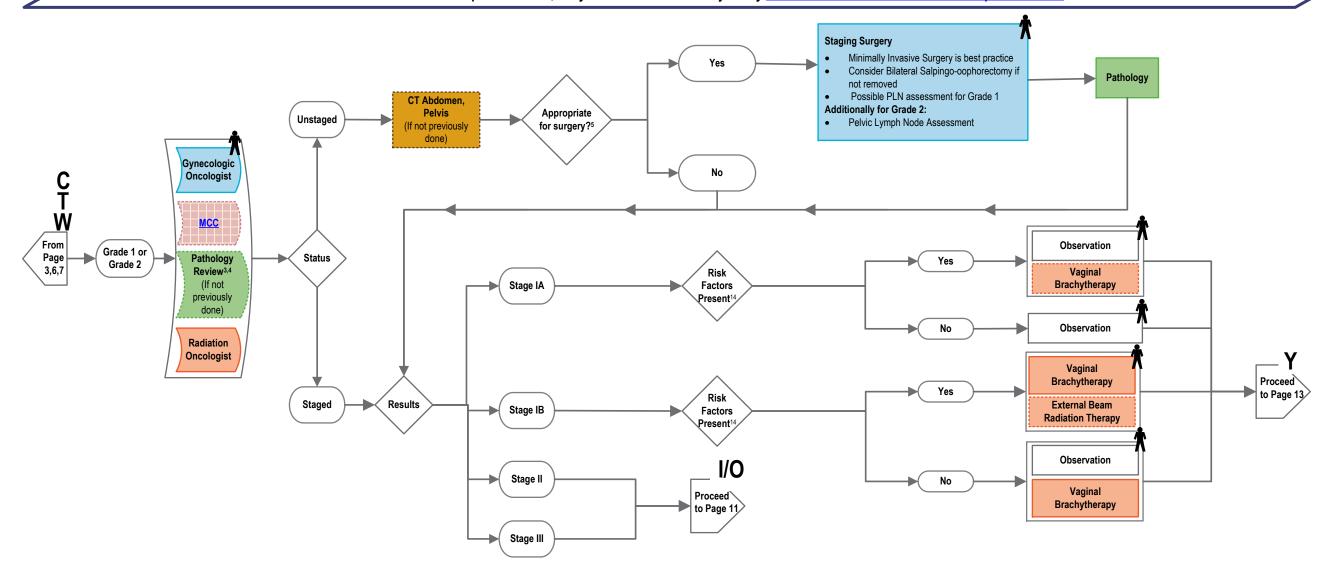
<sup>&</sup>lt;sup>9</sup> Suggested progestin therapy includes medroxyprogesterone, megestrol acetate, and levonorgestrel IUD

<sup>&</sup>lt;sup>12</sup> Consider omitting opphorectomy after thorough preoperative counselling with patien

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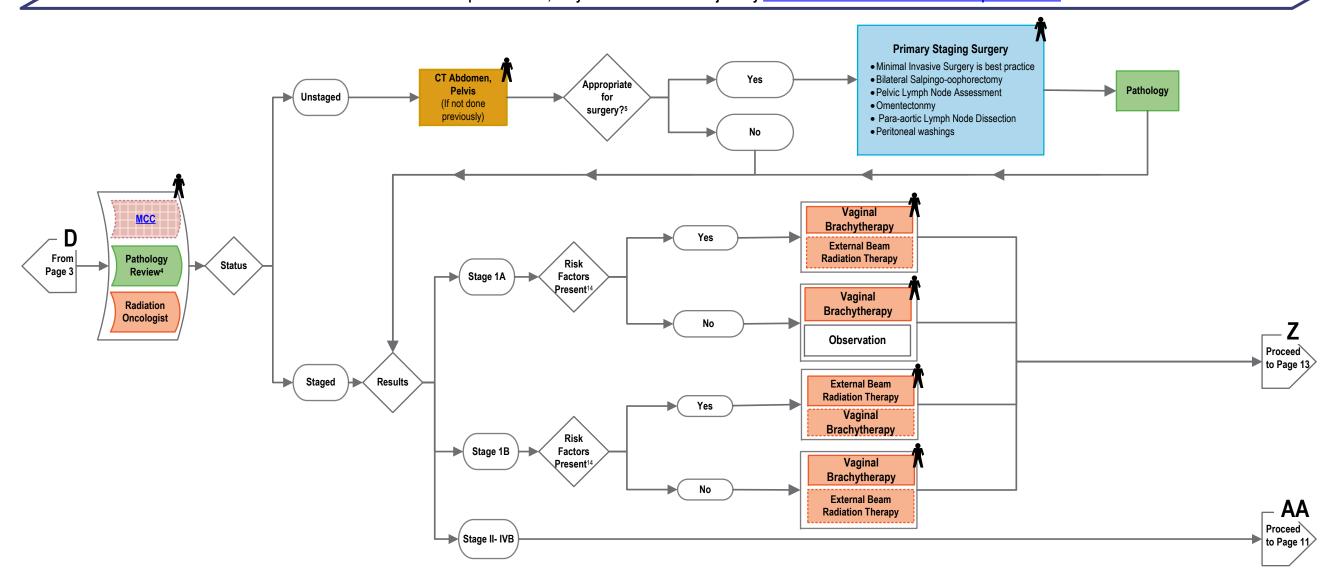
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<sup>14</sup> Risk factors include: age greater than 60 years based on Portec 1, positive lymphovascular invasion, deep myometrial invasion more than or equal to 50%

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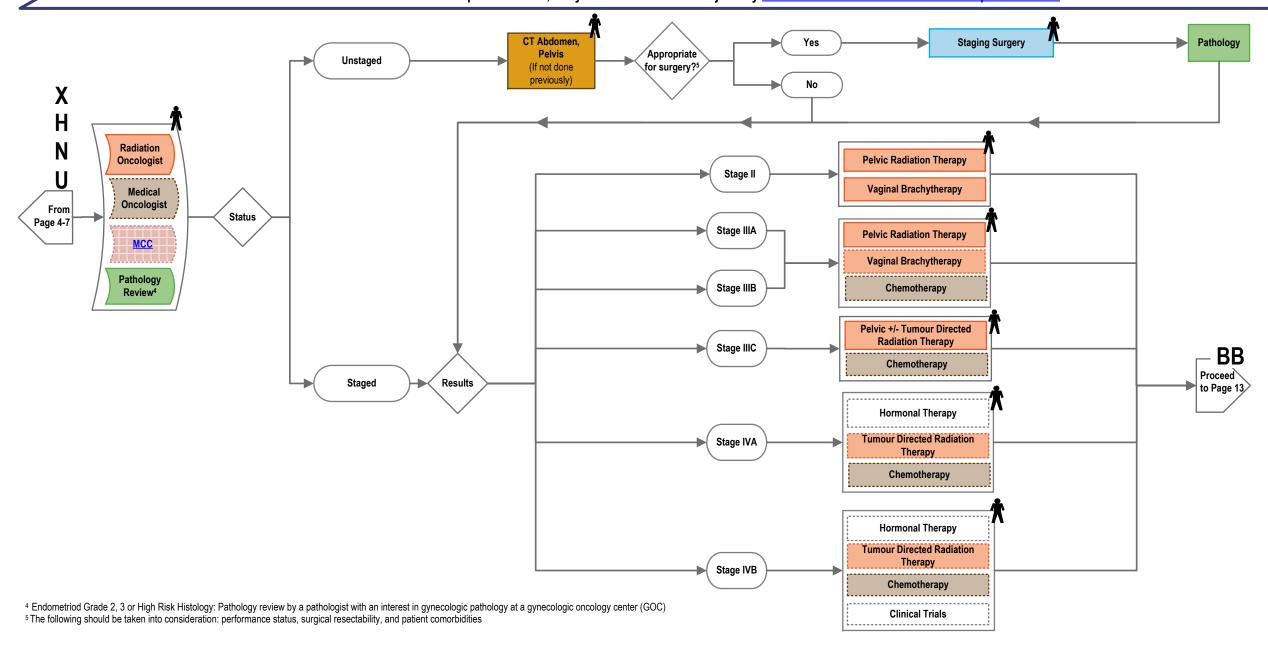


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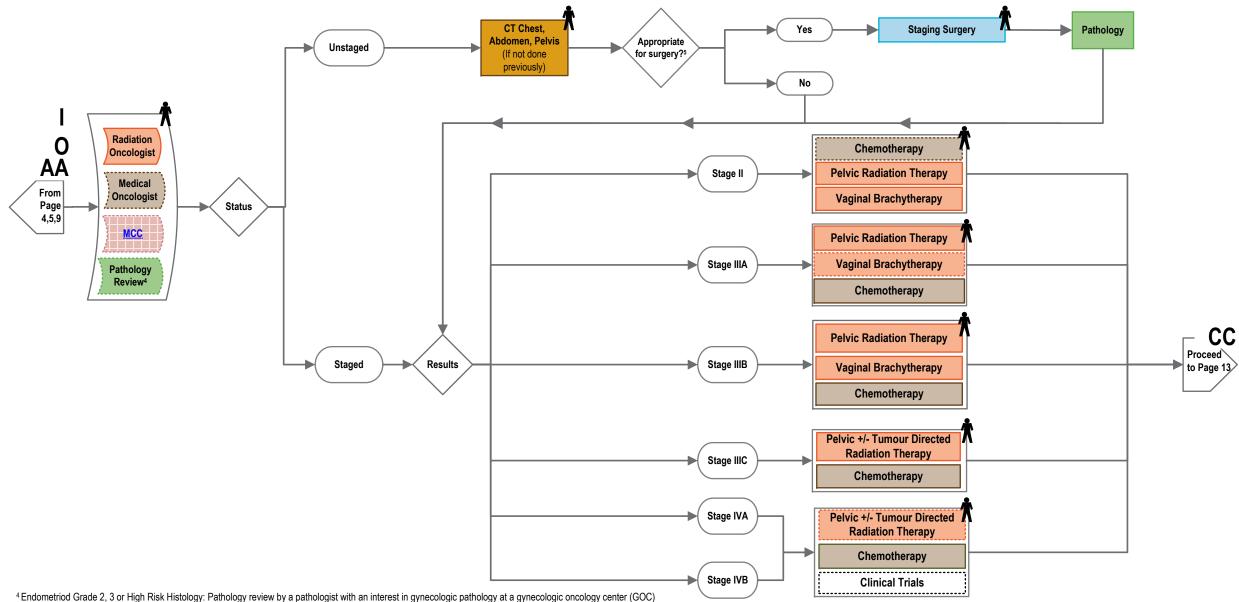
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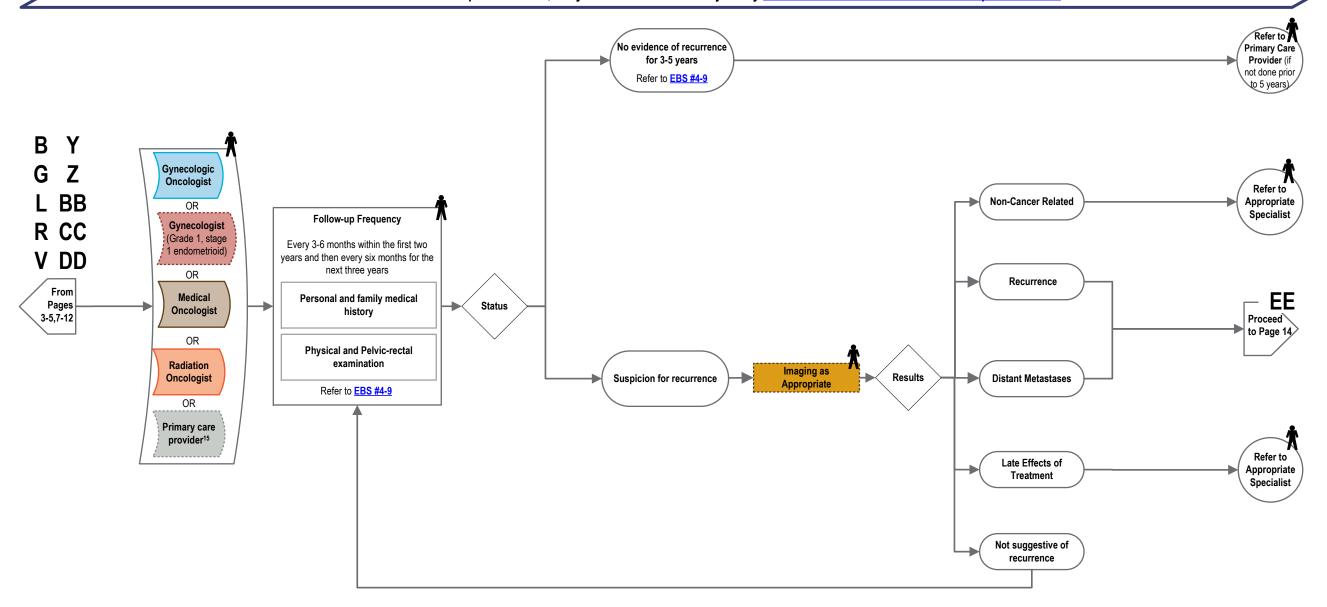
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Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care **Staging Surgery** Pelvic Lymph Node Assessment Appropriate Yes Pathology Para-aortic Lymph Node Unstaged (if not done Dissection surgery?5 No Stage IA/IB Status Vaginal Brachytherapy Radiation Medical **Pelvic Radiation Therapy** Oncologist Chemotherapy Staged Results Vaginal Brachytherapy Radiation Medical **Pelvic Radiation Therapy** From Oncologist Oncologist Gynecologic **Pages** Results Chemotherapy Oncologist Vaginal Brachytherapy Medical Radiation Stage II Pelvic Radiation Therapy Oncologist Oncologist Chemotherapy **Pelvic Radiation Therapy** Radiation Medical Proceed Stage IIIA Oncologist Oncologist to Page 13 Chemotherapy Stage IIIB Pelvic +/- Tumour Directed **Radiation Therapy** Radiation Medical Vaginal Brachytherapy Oncologist Oncologist Stage IIIC Chemotherapy Pelvic +/- Tumour Directed Radiation Medical Stage IVA Radiation Therapy Oncologist Oncologist Chemotherapy Pelvic +/- Tumour Directed Radiation Therapy Medical Stage IVB Oncologist Chemotherapy Oncologist Clinical Trial <sup>5</sup> The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities

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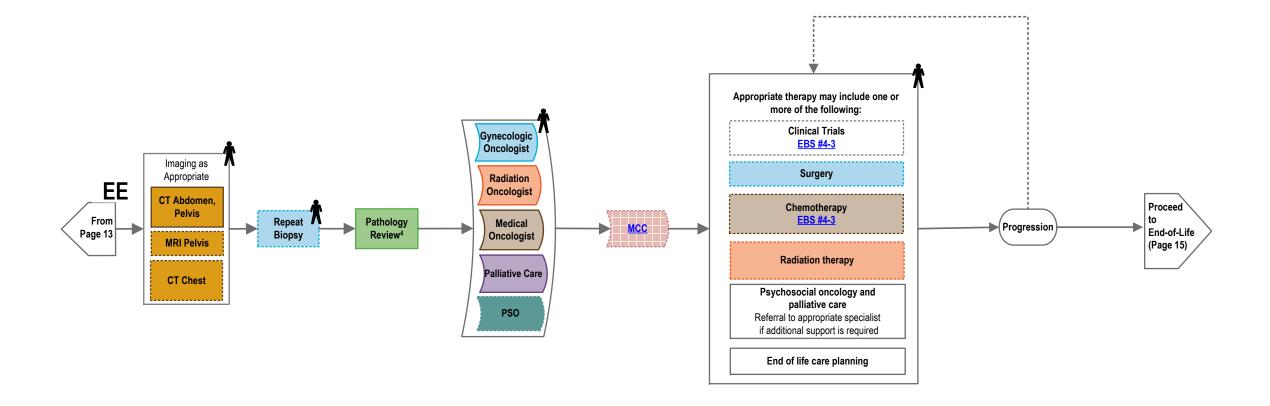


<sup>&</sup>lt;sup>15</sup> Appropriate for low risk stage 1a with no adjuvant therapy

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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



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Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

#### 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) **Triggers that** Screen, Assess. suggest patients ☐ Develop a plan of treatment and obtain consent **Pathway Map Target** Plan. Manage are nearing the • Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable) and Follow-Up **Population:** Develop a plan of treatment related to disease management that takes into account the person's values and mutually determined goals of care last few months Individuals with cancer • 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: and weeks life approaching end of life, and their - Setting for care families. - Resuscitation status ECOG/Patient-- Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.) While this section of the pathway ECOG/PRFS = 4 ☐ Screen for specific end of life psychosocial issues End of Life Care map is focused on the care OR delivered at the end of life, the Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young planning and PPS ≤ 30 palliative care approach begins implementation adults), quardianship of children, death anxiety Declining Collaboration and Consider referral to available resources and/or specialized services much earlier on in the illness performance trajectory. consultation status/functional ☐ Identify patients who could benefit from specialized palliative care services (consultation or transfer) Refer to Screen, Assess & Plan between ability Discuss referral with patients and family within the Psychosocial & specialist-level **Gold Standards Palliative Care Pathway Map** care teams and Framework ☐ Proactively develop and implement a plan for expected death primary care indicators of high Explore place-of-death preferences and assess whether this is realistic teams mortality risk • 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 to 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

## **Endometrial Cancer Treatment & Follow Up Pathway Map**

appropriate health care provider as required

**End of Life Care cont.** 

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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	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
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