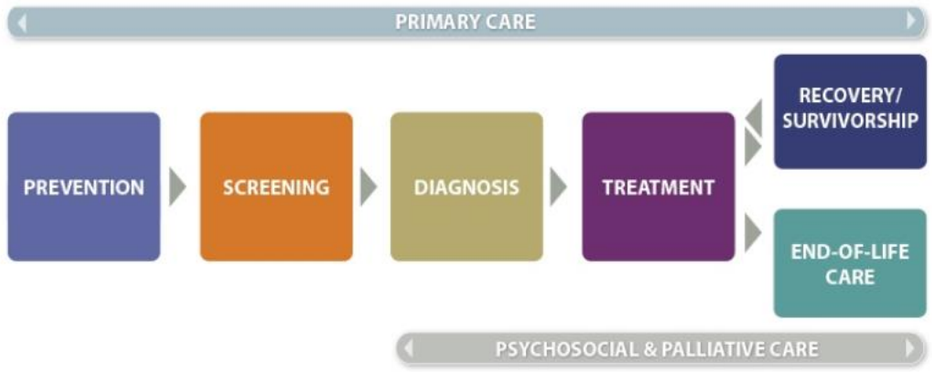
Cancer Care Ontario

Cervical Cancer Treatment Pathway Map

Disease Pathway Management

Version 2018.03



Disclaimer

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.

Ontario
Cancer Care Ontario

Target Population

Patients with a confirmed diagnosis of squamous or adenosquamous cervical cancer who have undergone the recommended diagnostic and staging procedures outline 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**
- The staging system used throughout the Cervical Cancer Treatment Pathway Map is the 2009 FIGO staging system.
- For patients who are receiving external beam radiation therapy with concurrent chemotherapy, the most responsible physician (MRP) for coordination of care should be a radiation oncologist.
- 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 **Person-Centered Care Guideline** and **EBS #19-2 Provider-Patient Communication***
- The term 'healthcare provider', used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, gynecologists, midwives and emergency physicians
- Hyperlinks are used throughout the pathway map to provide information about relevant CCO tools, resources and guidance documents.
- 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**
- 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
- Systemic therapy is used when other drugs (such as Bevacizumb) is available in addition to chemotherapy. Chemotherapy is used when traditional cytotoxic therapy is given.

* **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.

Pathway Map Legend

Colour Guide

- Primary Care
- Palliative Care
- Pathology
- Surgery
- Radiation Oncology
- Medical Oncology
- Radiology
- Gynecology
- Multidisciplinary Cancer Conference (MCC)
- Psychosocial Oncology (PSO) & Supportive Care

Shape Guide

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off-page reference
- Patient/Provider interaction
- Referral (R)
- Wait time indicator time point (W)

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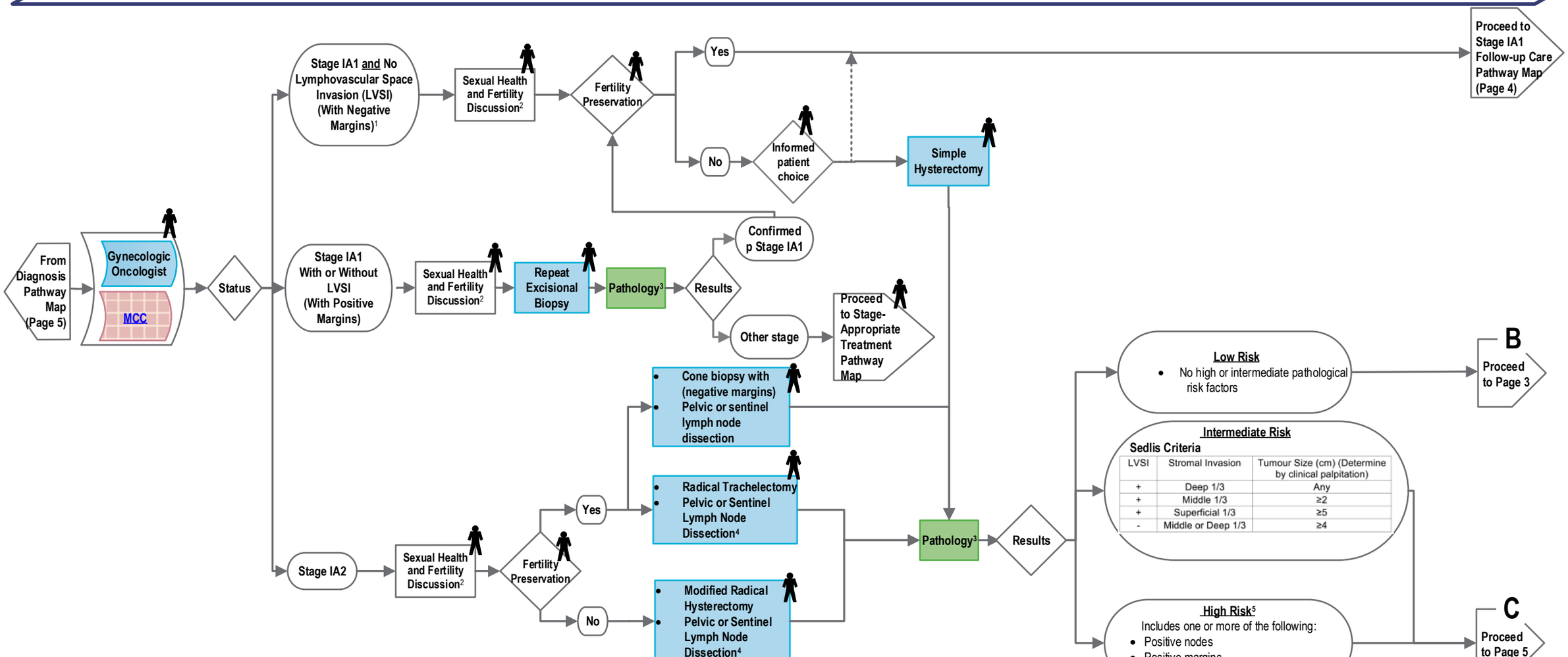
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

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



[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] Para-aortic lymph node sample may be needed if pelvic lymph node positive

[5] Completion of hysterectomy should be considered for patients who have undergone a radical trachelectomy and whose final pathology includes high risk features

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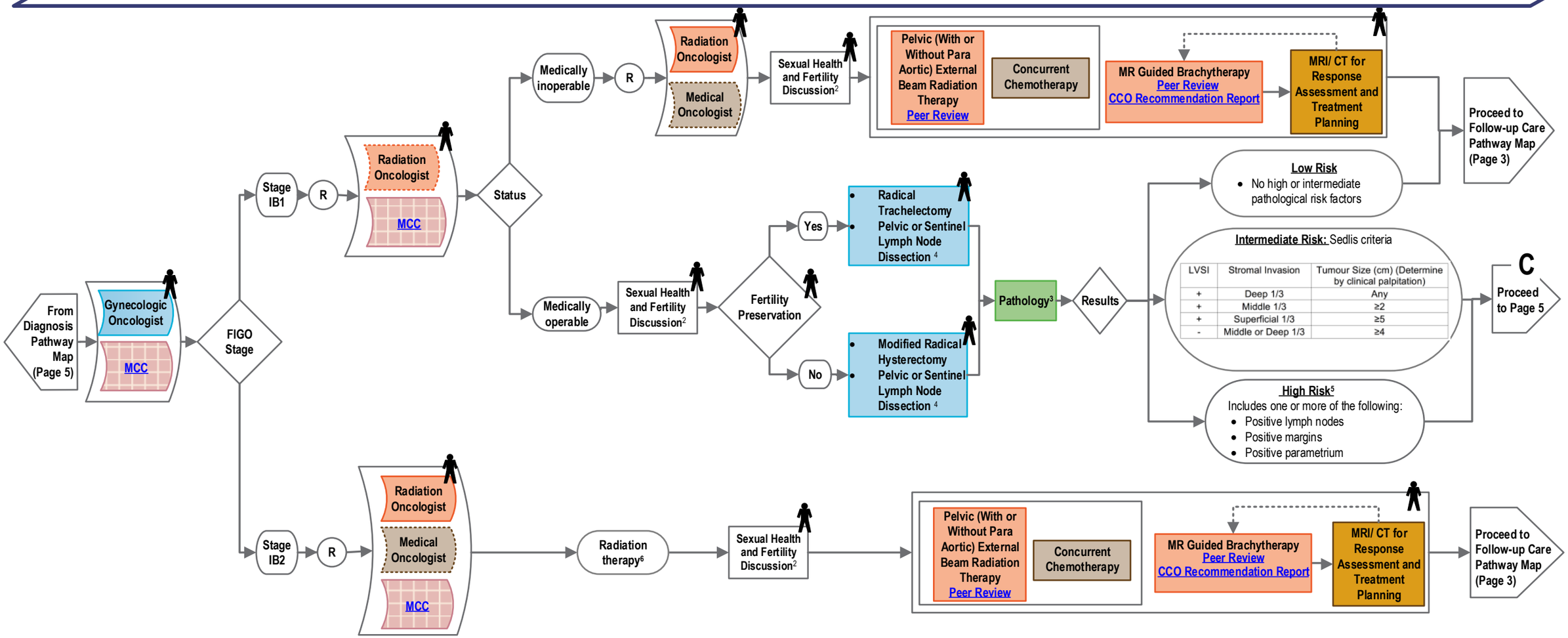

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[4] Para-aortic lymph node sample may be needed if pelvic lymph node positive
[5] Completion of hysterectomy should be considered for patients who have undergone a radical trachelectomy and whose final pathology includes high risk features
[6] Patients who are not suitable for or decide not to have radiation therapy proceed with surgery based on multidisciplinary decision

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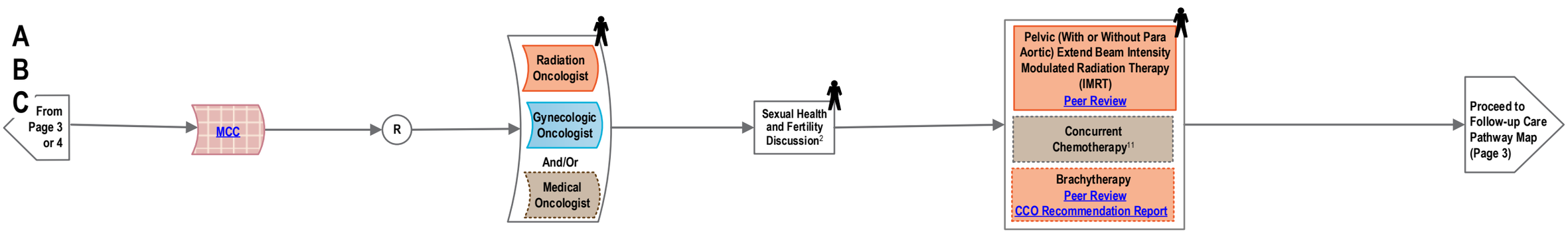

[2] Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc.

[11] Concurrent chemotherapy recommended for patients with "high" risk pathologic feature and may be considered for "intermediate" risk pathologic features.

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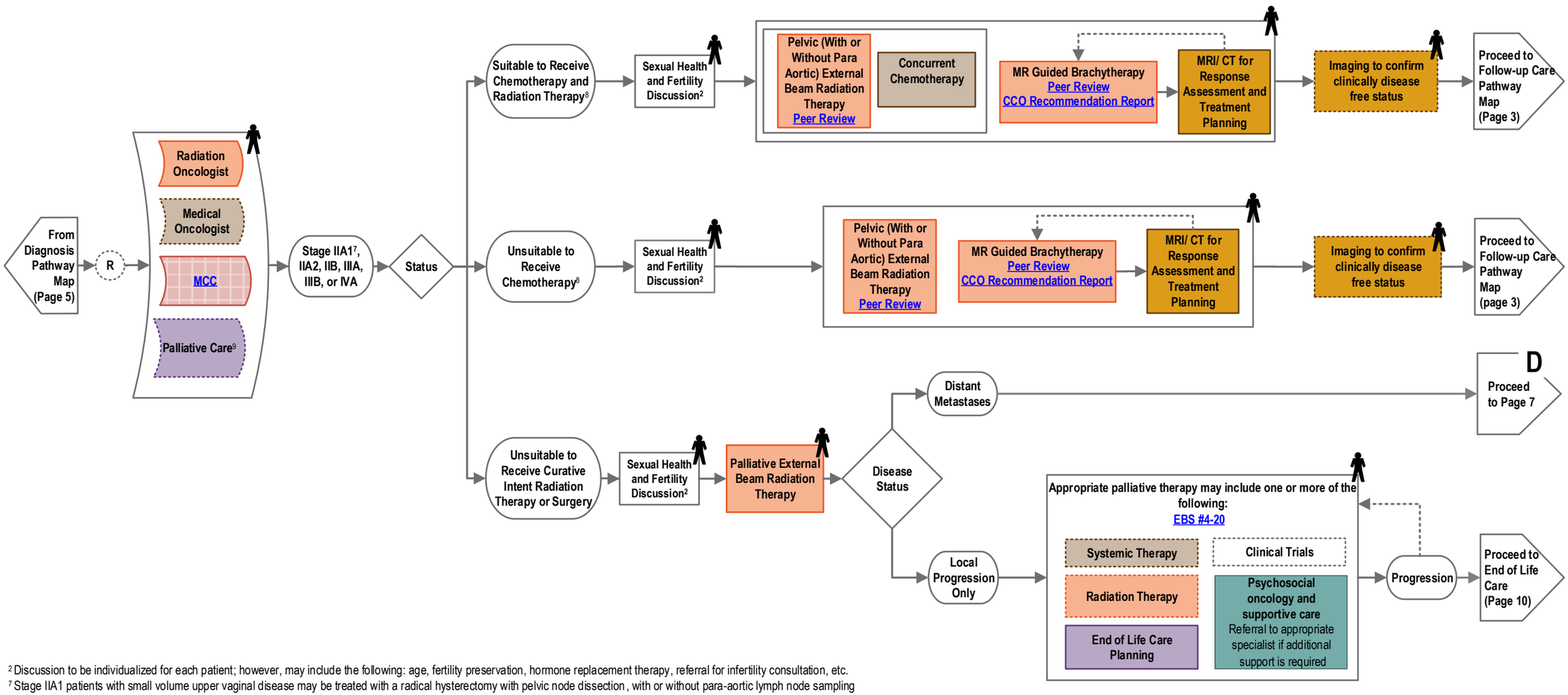

[2] Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc.
[7] Stage IIA1 patients with small volume upper vaginal disease may be treated with a radical hysterectomy with pelvic node dissection, with or without para-aortic lymph node sampling
[8] Nodal surgical debulking prior to radiation therapy may be considered

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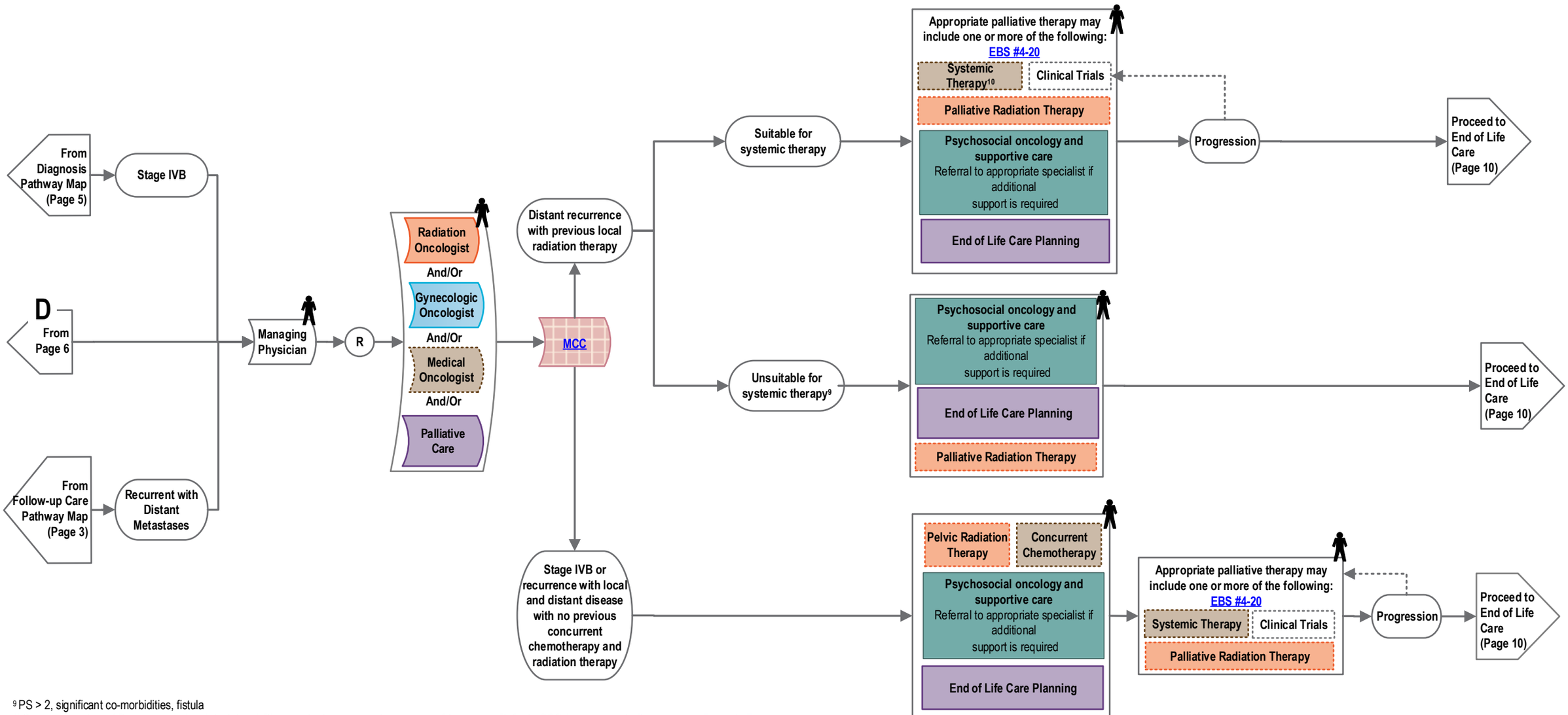

[9] PS > 2, significant co-morbidities, fistula

[10] Consider addition of Bevacizumab for Metastatic (IVB), persistent or recurrent carcinoma of the cervix. Refer to CCO for appropriate Bevacizumab Eligibility Form.

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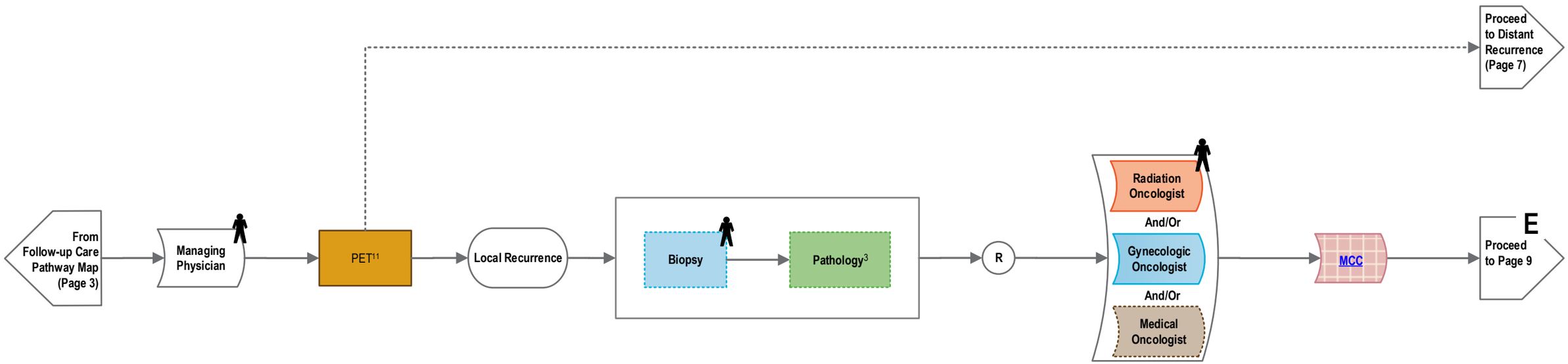

[3] Pathologists with a specialty or special interest in gynecologic pathology

[11] PET scan should be ordered if local vagina recurrence is found on CT/MRI

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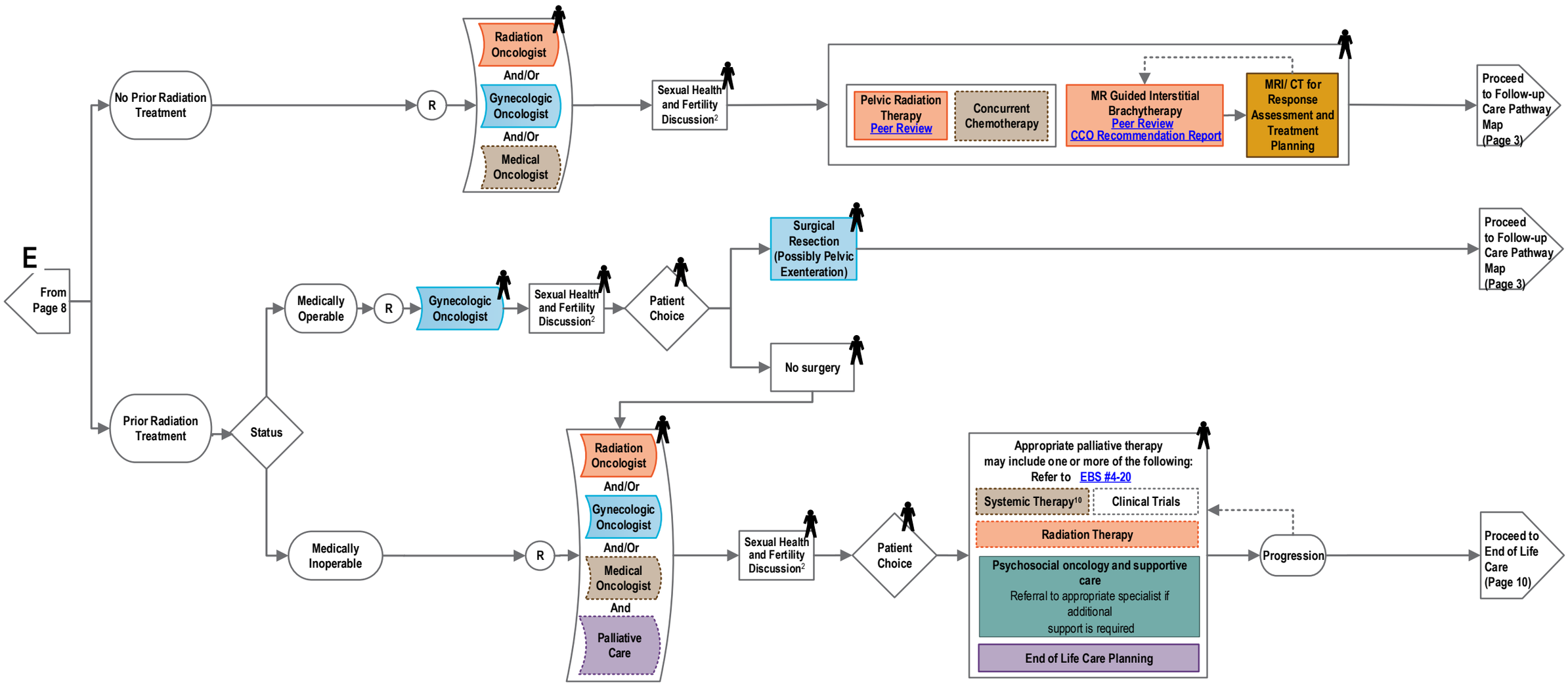

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Pathway Map Target Population:

Individuals with cancer approaching end of life, and their families.

While this section of the pathway map is focused on the care delivered at the end of life, the palliative care approach begins much earlier on in the illness trajectory.
Refer to Screen, Assess & Plan within the Psychosocial & Palliative Care Pathway Map

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

- **ECOG/Patient-ECOG/PRFS = 4**
  OR
- **PPS ≤ 30**
- **Declining performance status/functional ability**
- **Gold Standards Framework indicators of high mortality risk**

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

End of Life Care

☐ **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)

☐ **Develop a plan of treatment and obtain consent**

- Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable)
- Develop a plan of treatment related to disease management that takes into account the person's values and mutually determined goals of care
- 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:
  - Setting for care
  - Resuscitation status
  - Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.)

☐ **Screen for specific end of life psychosocial issues**

- Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Consider referral to available resources and/or specialized services

☐ **Identify patients who could benefit from specialized palliative care services (consultation or transfer)**

- Discuss referral with patients and family

☐ **Proactively develop and implement a plan for expected death**

- Explore place-of-death preferences and assess whether this is realistic
- 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 2-4 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

Eastern Cooperative Oncology Group Performance Status (ECOG); Palliative Performance Scale (PPS); Patient Reported Functional Status (PRFS)
For more information on the Gold Standards Framework, visit http://www.goldstandardsframework.org.uk/