Disclaimer
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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. For patients who do not have a primary care provider, Health Care Connect is a government resource that helps patients find a family doctor or nurse practitioner.
- Throughout the pathway, 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.
- Hyperlinks are used throughout the pathway to provide information about relevant CCO tools, resources and guidance documents.
- The term 'health care provider', used throughout the pathway, includes primary care providers and specialists, nurse practitioners, otolaryngologists, speech language pathologists, registered dietitians, and emergency physicians.
- 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. PSO support may include social worker and psychiatric support. Psychiatric support may be provided by a Psychologist, a Psychiatrist or by a Primary Care Provider. For more information, visit EBS #19-3.
- 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.
- The following should be considered when weighing the treatment options described in this pathway 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.
- For more information on the systemic treatment GBP please refer to the Quality-Based Procedures Clinical Handbook for Systemic Treatment.
- Counseling and treatment for smoking cessation should be initiated early on in the pathway and continued by care providers throughout the pathway as necessary. Program Training & Consultation Centre – Hospital Based Resources.
- Organizational Guidance for the Care of Patients with Head and Neck Cancer (in Ontario) recommendations apply across this pathway and establish the minimum requirements to maintain a head and neck disease site program.
- MCC Tools
- *Note. EBS #19-3 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
- Multidisciplinary Cancer Conference (MCC)
- Psychosocial Oncology (PSO)

**Shape Guide**

- Intervention
- Decision or assessment point

- Consultation with specialist
- Exit pathway map
- Referral
- Wait time indicator time point

**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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This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. CCO 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.
HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

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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]

Note. EBS 8.6-11 is currently listed as ‘In Review’.

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1 All patients should have access to specialized oncology nurse, clinical nurse specialist or nurse practitioner to manage the complex physical, social and psychological health needs that arise during treatment and in early follow-up post treatment.
2 Some patients may require on-going direct care with their Primary Care Provider during treatment.
3 Surgery may be an option for some patients. Patients should be included in trials investigating Transoral Robotic Surgery (TORS) where available.
4 Indications for post-operative radiotherapy: Deep margins <5mm OR one or more of the following at the primary site: per-neural invasion, lympho-vascular invasion OR lymph node involvement (≥ 2 lymph nodes, any lymph node ≥ 3 cm (N2+), nodal level IV-V LN positive, extracapsular extension (ECE)).
5 Indications for concurrent chemotherapy: positive margins or extracapsular extension (ECE).
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**Stage III**

Any T, N3, M0

T4, Any N, M0

AJCC Cancer Staging Manual 8th edition

UICC The TNM Classification of Malignant Tumours, 8th Edition

**From Diagnosis**

Pathway Map (Page R)

**GL 5-30RG**

Medical Oncologist

Dental Oncologist

MOC or MDT

Registered Dietitian

Speech Language Pathologist

Nursing1

Social Worker

PSO Support

Otolaryngologist

Smoking Cessation Program

Primary Care Provider1

**Blood Work**

Dental Evaluation

Nutrition, speech and swallowing evaluation/therapy, and dysphagia prevention

Psychosocial Intervention may include:

- Financial: disability, drug benefits
- Transportation
- Placement
- Counselling regarding diagnosis, appearance changes & HPV

Feeding Tube Placement

Audiometry

Smoking cessation counselling & intervention where appropriate

OT4a: Gross bone invasion

Surgery1:

- Indications include: Contraindications for radiation therapy. Patient choice, previous radiation

**Surgical Management of Primary and Neck**

(All nodal levels II-IV and those with clinical or radiographic evidence disease) GL 5-30RG

**Pathology**

**Concurrent Chemotherapy**

Orthotopic Neck Node Ablation (O-NNA) OR Conventional Radiation Therapy

**Targeted Therapy**

**Or**

**Chemotherapy**

**Pathway Map**

**Age ≤ 70**

**Radiation Therapy**

**Age > 70**

**During Treatment**

On Treatment Review:

- Radiation Medicine Clinician
- Oncology Nurse
- Patients should also have access to:
  - Clinical Nurse Specialist / Nurse Practitioner
  - Registered Dietitian
  - Speech Language Pathologist
  - Dental Oncology
  - Social Worker

**Otoxicity Management**

If patient is on chemotherapy

**Concurrent Chemotherapy2**

Pathway Map (Page F)

**Yes**

**Concurrent Chemotherapy2**

**No**

**Surgical Management of Primary and Neck**

Indications for concurrent chemotherapy: positive margins or extracapsular extension (ECE).
Stage IV Metastatic Disease

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.

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HPV-Positive Oropharyngeal Squamous Cell Carcinoma Treatment Pathway Map

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1. All patients should have access to specialized oncology nurse, clinical nurse specialist or nurse practitioner to manage the complex physical, social and psychological health needs that arise during treatment and in early follow-up post treatment.

2. Platinum-containing agents (single or multi-agent) alone or in combination with other agents; other systemic therapy options may also exist including targeted therapies such as Nivolumab as indicated. Consider referral to Head & Neck centre.

---

Stage IV

- Any T; Any N; M1
- AJCC Cancer Staging Manual 8th edition
- UICC The TNM Classification of Malignant Tumours, 8th Edition

---

Blood Work

- Extent of Disease

- Nutritional, speech and swallowing evaluation/therapy, and dysphagia prevention

Psychosocial Intervention

- May include:
  - Financial: disability, drug benefits
  - Transportation
  - Placement
  - Counselling regarding diagnosis, appearance changes & HPV

Feeding Tube Placement

Audiometry

In the recurrent and metastatic scenario, patients may require any and all of the same supportive care as patients undergoing primary treatment.

---

From Diagnosis Pathway (Page 5)

K

From Page 7

GL 5-3ORG

- Dental Oncologist
- MCC or MDT
- Registered Dietitian
- Speech Language Pathologist
- Nursing
- Social Worker
- PSO Support
- Audiologist
- Smoking Cessation Program
- Medical Oncologist
- Palliative Care

---

Consider aggressive local therapies

- And/or

- Systemic Therapy

---

Disseminated metastases

Fit for systemic therapy?

---

Systemic Therapy

- (e.g. Targeted therapy or chemotherapy)

---

Recurrence or Progression

End of Life Care Pathway Map (Page 12)

---

Appropriate therapy may include one or more of the following:

- Palliative Systemic Therapy
- Palliative Radiation Therapy
- Palliative Surgery
- Psychosocial oncology and palliative care

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Clinical Trials
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.

GL 5-3ORG
- Dental Oncologist
- MCC or MDT
- Registered Dietitian
- Speech Language Pathologist
- Psychosocial Intervention
  - May include:
    - Financial: disability, drug benefits
    - Transportation
    - Placement
    - Counseling regarding diagnosis, appearance changes & HPV
- Feeding Tube Placement
- Audiology
- In the recurrent and metastatic scenario, patients may require any and all of the same supportive care as patients undergoing primary treatment

Blood Work
- Dental Evaluation
- Nutrition, speech and swallowing evaluation/therapy, and dysphagia prevention

Restaging, if not previously done
- Tissue Biopsy
- Locoregional Imaging: CT Head & Neck or MRI Nasopharynx and Oropharynx
- CT Thorax
- CT Abdomen
- PET/CT Scan Oesophagus

<table>
<thead>
<tr>
<th>Type of recurrence</th>
<th>Local Recurrence</th>
<th>Regional Recurrence</th>
<th>Metastatic</th>
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<tbody>
<tr>
<td>I</td>
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</tbody>
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From Page 9
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.

4 Indications for post-operative radiotherapy: Deep margins <5mm OR one or more of the following at the primary site: perineural invasion, lymph-vascular invasion OR lymph node involvement (≤2 lymph nodes, any lymph node >3 cm (N2+)), level II/III/IV/V/LNR positive, extracapsular extension (ECE).

5 Indications for concurrent chemotherapy: positive margins or extracapsular extension (ECE).

6 Surgery may be an option for some patients if procedure can be completed in conservatively/transorally. Patients should be included in trials investigating Transoral Robotic Surgery (TORS) where available.

7 Appropriateness of concurrent chemotherapy with re-irradiation should be considered on an individual basis after discussion with a multidisciplinary team.
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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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
Follow-Up

Every 3 months for year 1,
Every 4 months for year 2,
Every 6 months for year 3-5

Imaging
- Frequency determined as indicated by clinical suspicion of recurrent disease

Blood Work
- May include Complete Blood Count (CBC) and Thyroid Stimulating Hormone (TSH)

History
- Including swallowing function and pain

Physical Examination
- Including indirect inspection or fibre-optic nasendoscopy

Assessment and management of treatment-related symptoms and side effects

Dental Assessment
- In previously irradiated patients, extractions must be performed by dental oncologists or dentists experienced in head and neck cancers due to risk of osteoradionecrosis

Audiology or ophthalmology assessment

Management of treatment-related symptoms and side effects

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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)

- 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
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