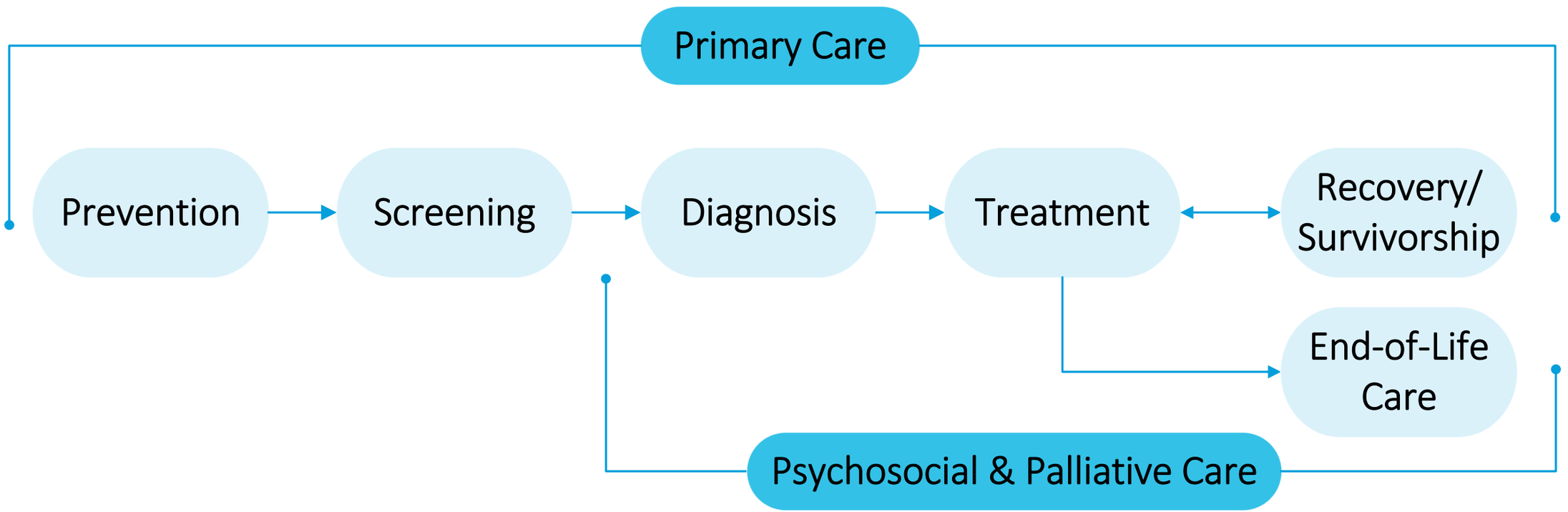
Prostate Cancer Treatment Pathway Map

Version 2024.10



Ontario Health
Cancer Care Ontario

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 they have 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 Ontario Health (Cancer Care Ontario) and the reader.

Target Population

- Patients with a confirmed prostate cancer diagnosis who have undergone the recommended diagnostic and staging procedures outlined in the **Prostate Cancer Diagnosis Pathway**.

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-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, 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 Wait Times
- 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.*

Pathway Map Legend

Colour Guide

- Primary Care
- Palliative Care
- Pathology
- Organized Diagnostic Assessment
- Surgery
- Radiation Oncology
- Medical Oncology
- Radiology
- Multidisciplinary Cancer Conference (MCC)
- Genetics
- Psychosocial Oncology (PSO)

Shape Guide

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off page reference (or)
- Referral (R)

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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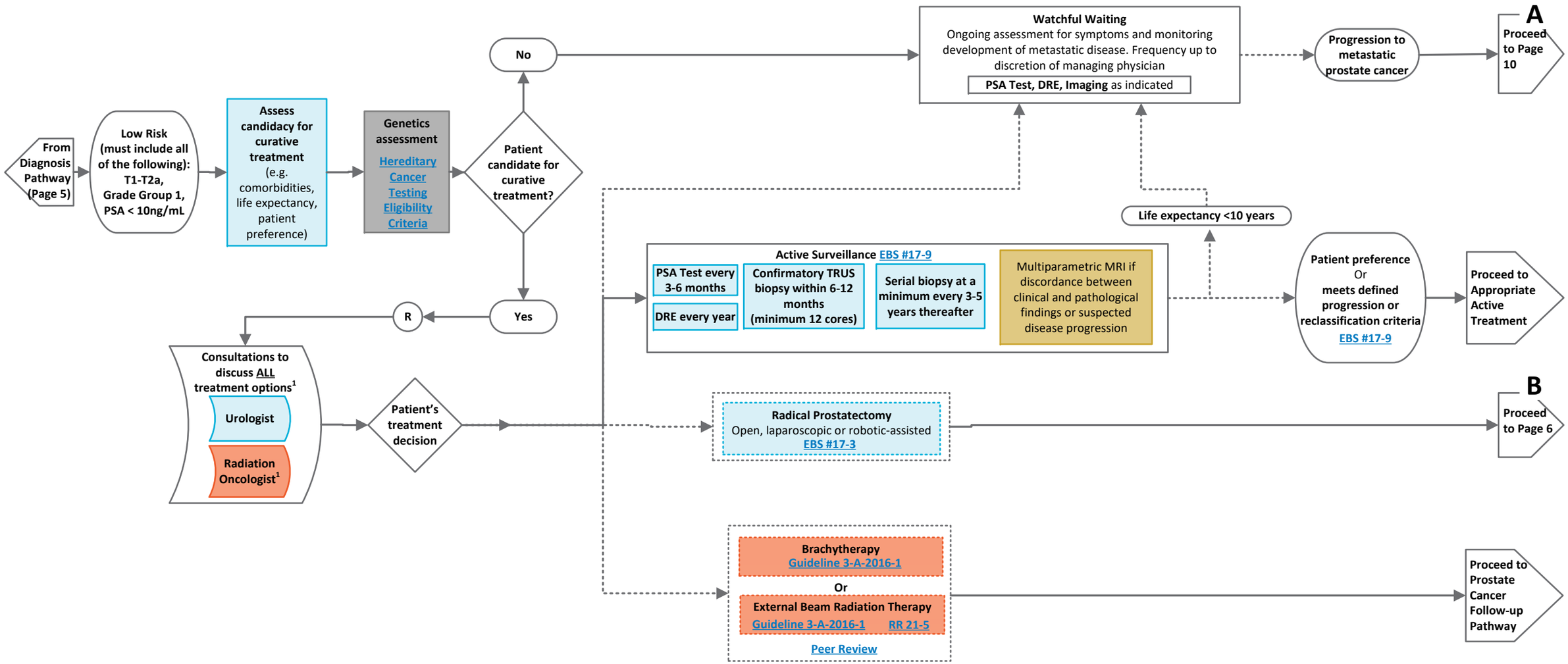
* **Note. EBS #19-2 and EBS #19-3** are older than 3 years and are currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

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



[1] For patients with low-risk prostate cancer who require or choose active treatment, low–dose rate brachytherapy (LDR) alone, EBRT alone, and/or radical prostatectomy (RP) should be offered to eligible patients.

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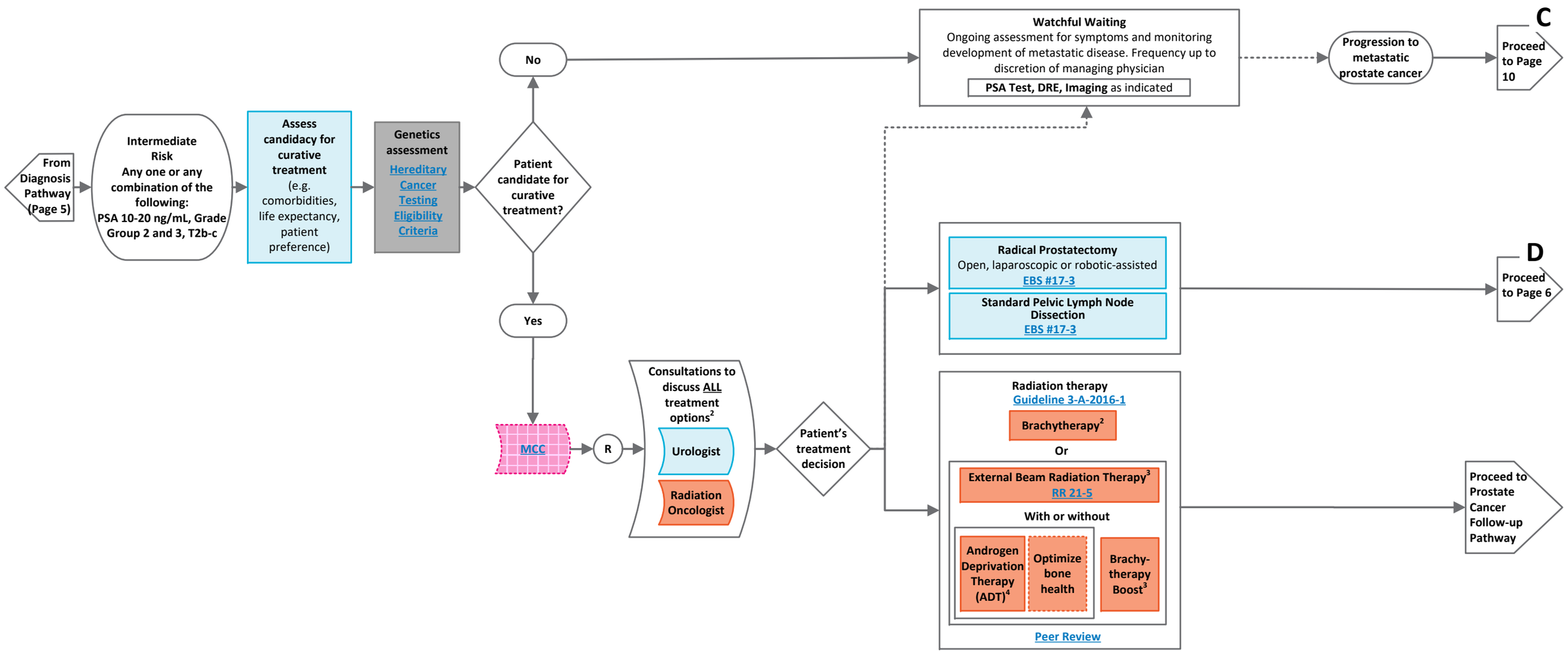

[2] For low-intermediate risk prostate cancer (Grade Group 2 & prostate-specific antigen 10 ng/mL or Gleason 6 & prostate-specific antigen 10 to 20 ng/mL), brachytherapy alone may be offered as monotherapy.
[3] For patients with intermediate-risk prostate cancer choosing EBRT with or without androgen-deprivation therapy, brachytherapy boost (low-dose rate or high–dose rate) should be offered to eligible patients.

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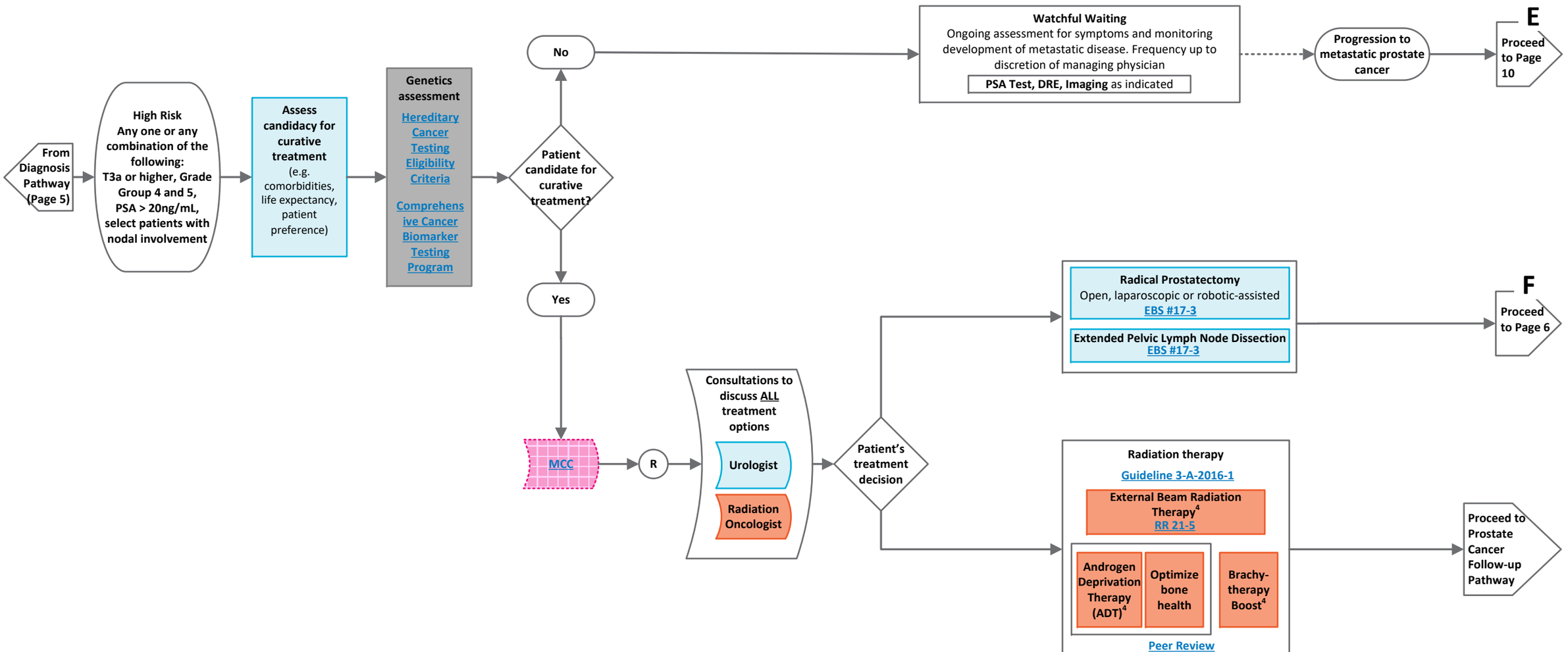

[4] Androgen-deprivation therapy (ADT) is a standard for patients with high-risk prostate cancer treated with radiotherapy. ADT may be given in neoadjuvant, concurrent, and/or adjuvant settings at physician discretion. For patients with high-risk prostate cancer receiving EBRT and ADT, brachytherapy boost (LDR or HDR) should be offered to eligible patients.

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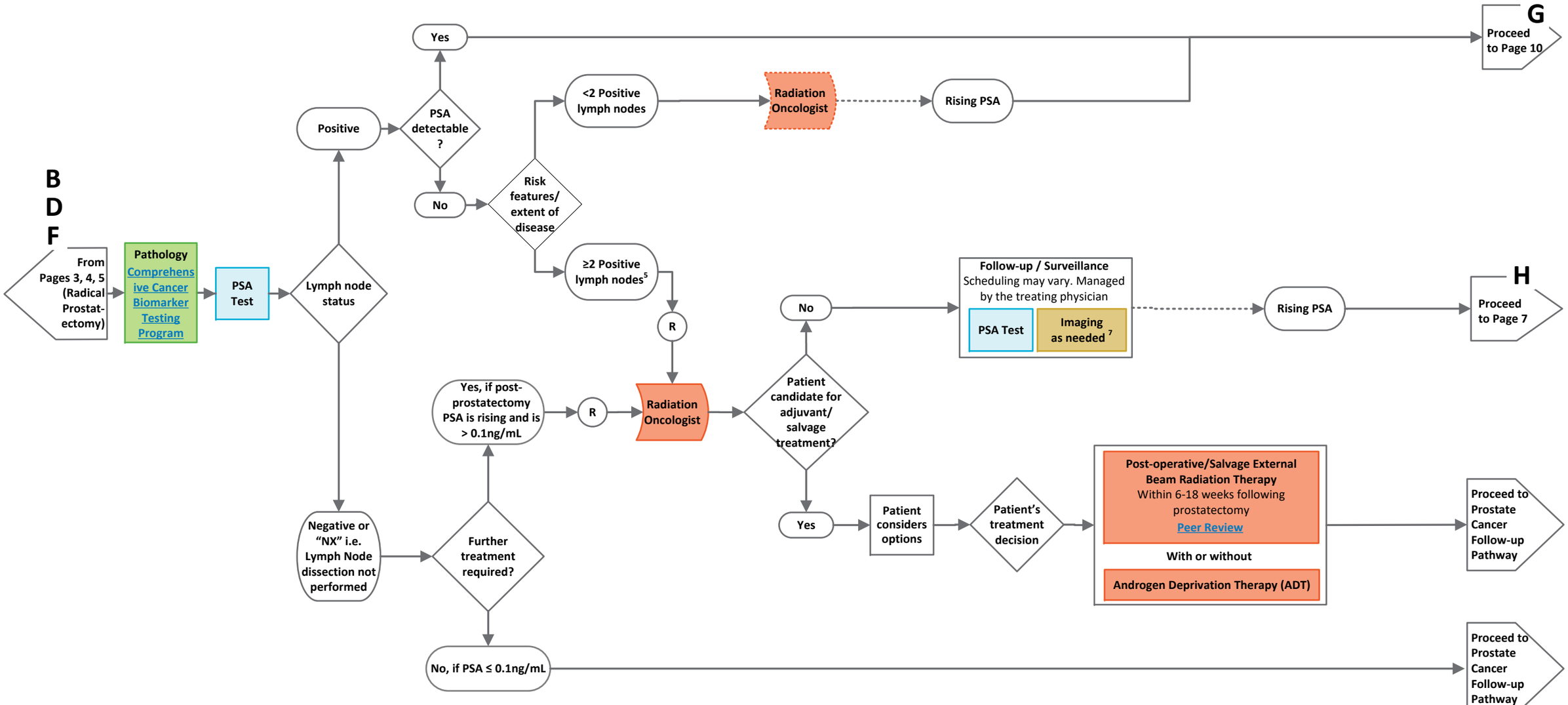

[5] Local high risk features: Grade Group 2 and 3, pT3b or pT4 stage, positive surgical margins
[7] Image if there is a display of clinical symptoms and considered intermittently.

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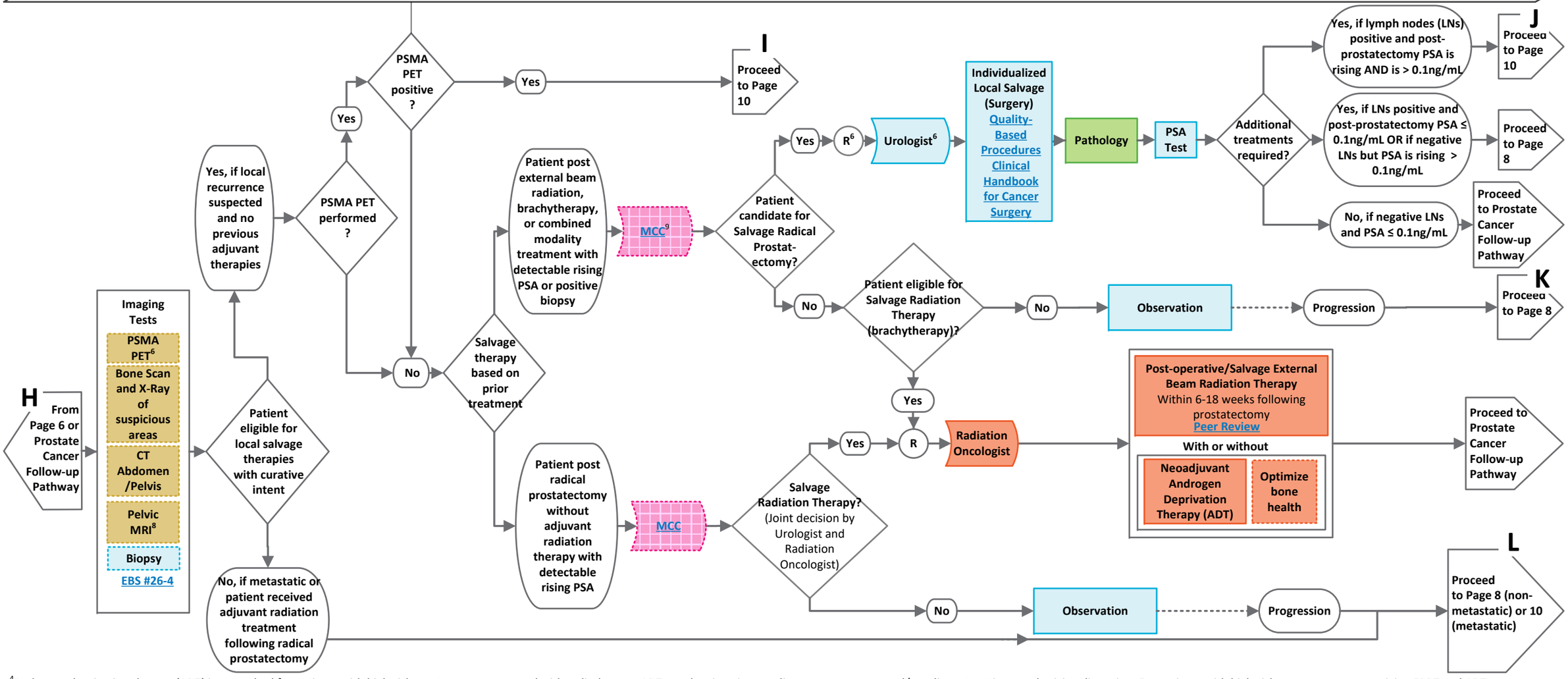

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[6]For a list of centres offering PSMA PET, please visit: PSMA-PET for Prostate Cancer Requisition to PET Centre

[8] MRI is appropriate when used for targeted biopsy

[9] Salvage radical prostatectomy following radiation therapy should be performed and offered at centres of known expertise

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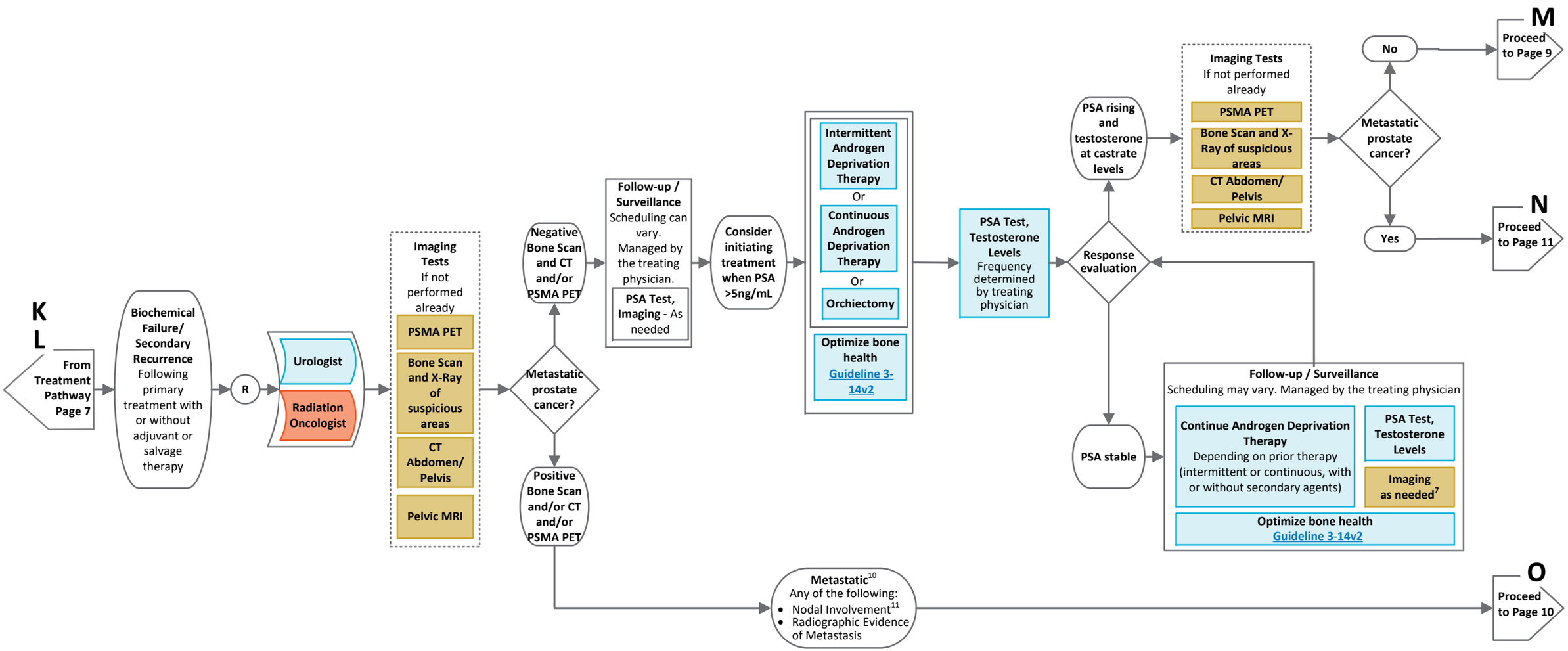

[7] Image if there is a display of clinical symptoms and considered intermittently.
[10] Oligometastatic patients should be discussed at MCC for personalized care.
[11] Select patients with nodal involvement can be managed with the high risk/locally advanced pathway.

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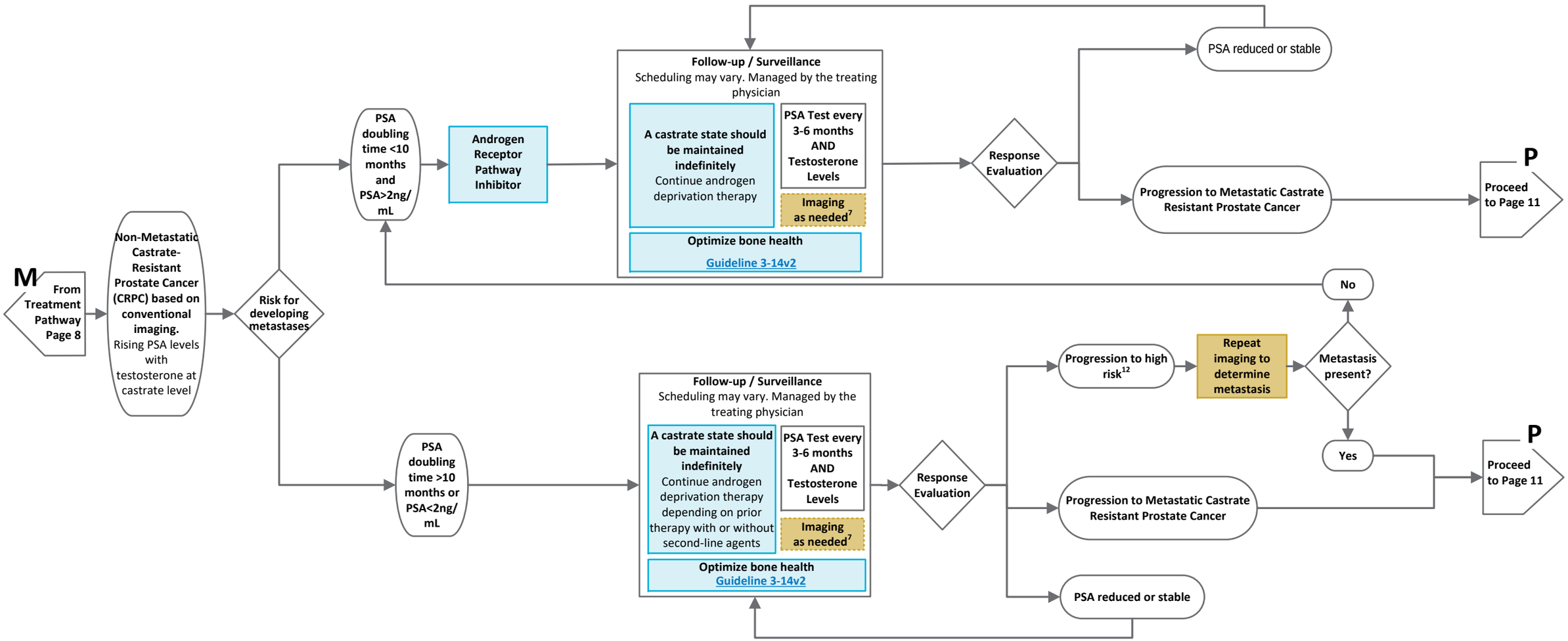

[7] Image if there is a display of clinical symptoms and considered intermittently.

[12] High risk is defined as PSA doubling time <10 months, PSA > 2 ng/mL; Low risk is defined as PSA doubling time greater than 10 months, PSA < 2ng/mL.

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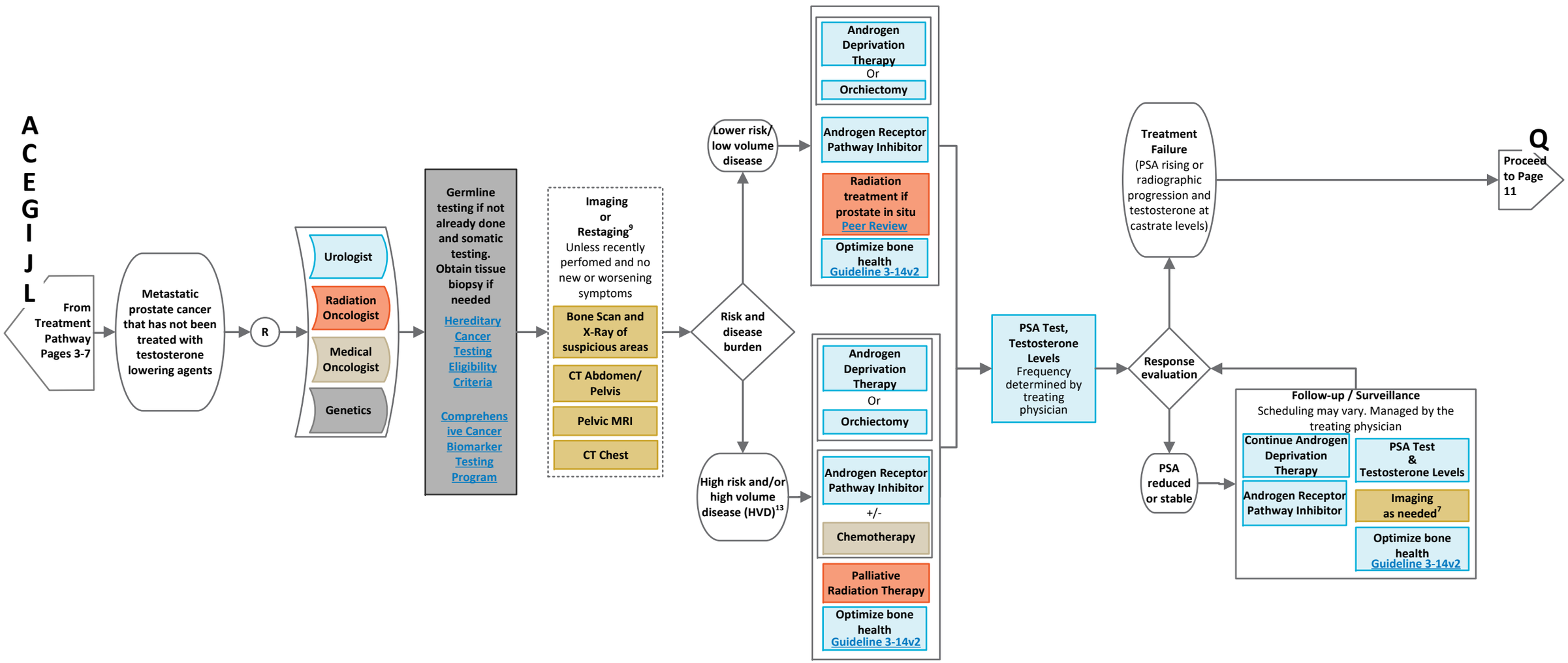

[7] Image if there is a display of clinical symptoms and considered intermittently.

[13] High volume defined as visceral metastases and/or 4 or more bone metastases (at least 1 beyond pelvis and vertabral column) OR High risk is defined by high-risk factors associated with a poor prognosis including at least two of the following high-risk factors: a Gleason score ≥ 8, at least three bone lesions, and presence of measurable visceral disease.

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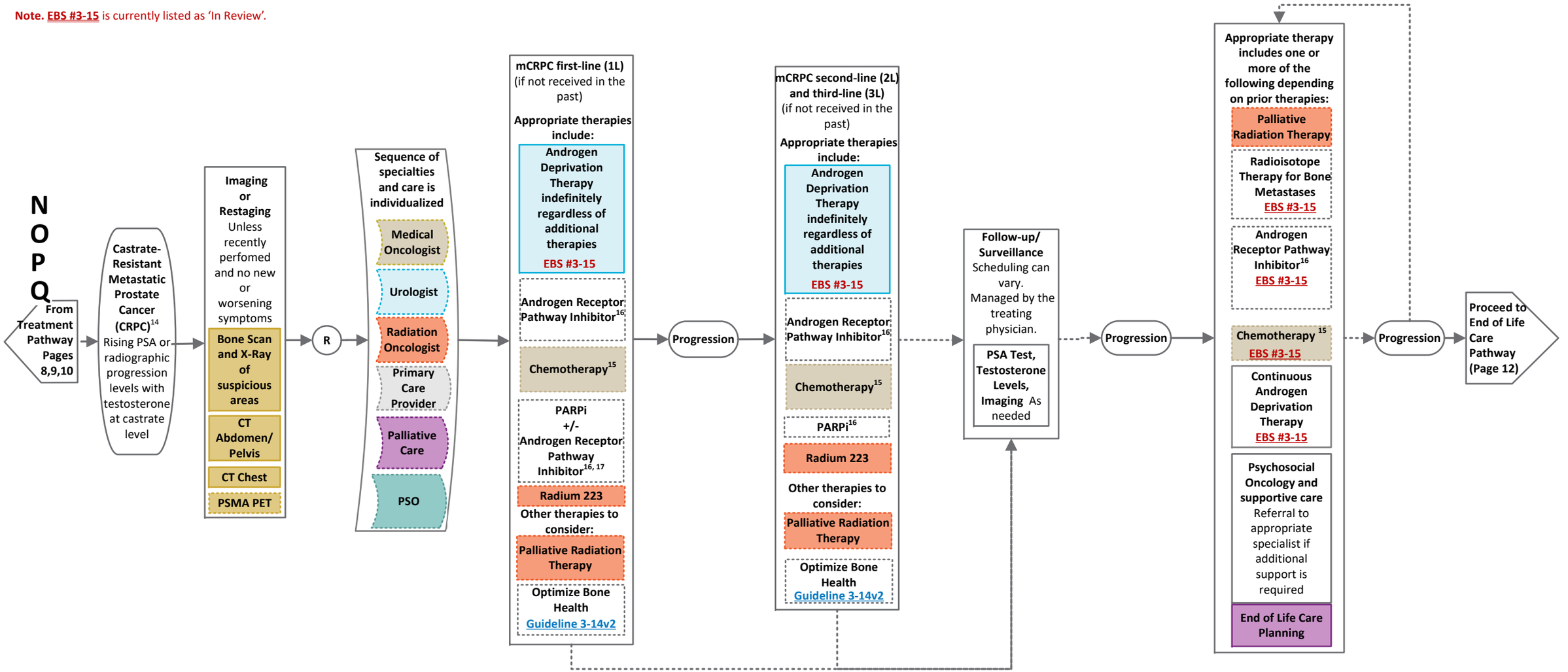
Note. EBS #3-15 is currently listed as 'In Review'.



[14] All patients should have germline and somatic (when possible) testing .
[15] Docetaxel/prednisone should be offered. Cabazitaxel and prednisone may be offered to men who experience progression with docetaxel.
[16] Therapies with demonstrated survival and quality-of-life benefits are abiraterone acetate/prednisone; enzalutamide.
[17] PARPi monotherapy if prior ARPI otherwise consider combination therapy.

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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

- Eastern Cooperative Oncology Group (ECOG) Performance Status/Patient-ECOG/Patient Reported Functional Status (PRFS) = 4
  OR
- Palliative Performance Scale (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 specialist-level 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

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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 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