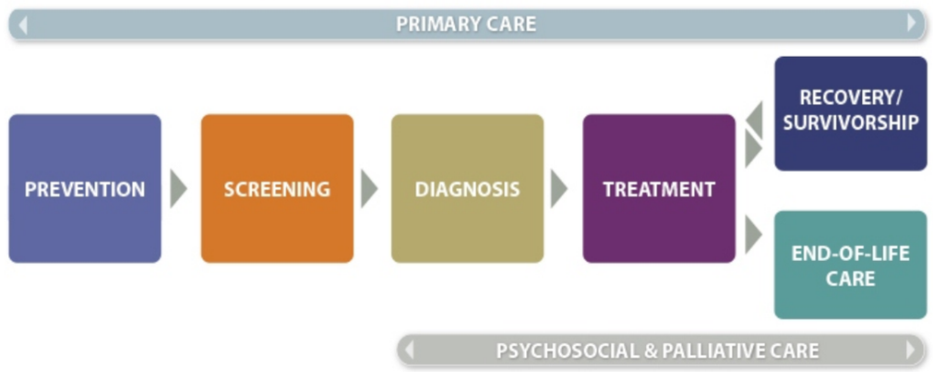
Cancer Care Ontario

# Prostate Cancer Treatment Pathway

Version 2018.03






Ontario
Cancer Care Ontario

## 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, **Health Care Connect,** is a government resource that helps patients find a family 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 CCO 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.
- Counseling and treatment for smoking cessation should be initiated early on in the pathway map and continued by care providers throughout the pathway map as necessary. **Program Training & Consultation Centre – Hospital Based Resources**
- In order to minimize delays, processes may be carried out in parallel if disease management is not affected.
- 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: (1) 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, (2) 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 QBP please refer to the **Quality-Based Procedures Clinical Handbook for Systemic Treatment**

* **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 Legend

### Colour Guide

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

### Shape Guide

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

### Line Guide

- Required
- Possible

## Pathway Disclaimer

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

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

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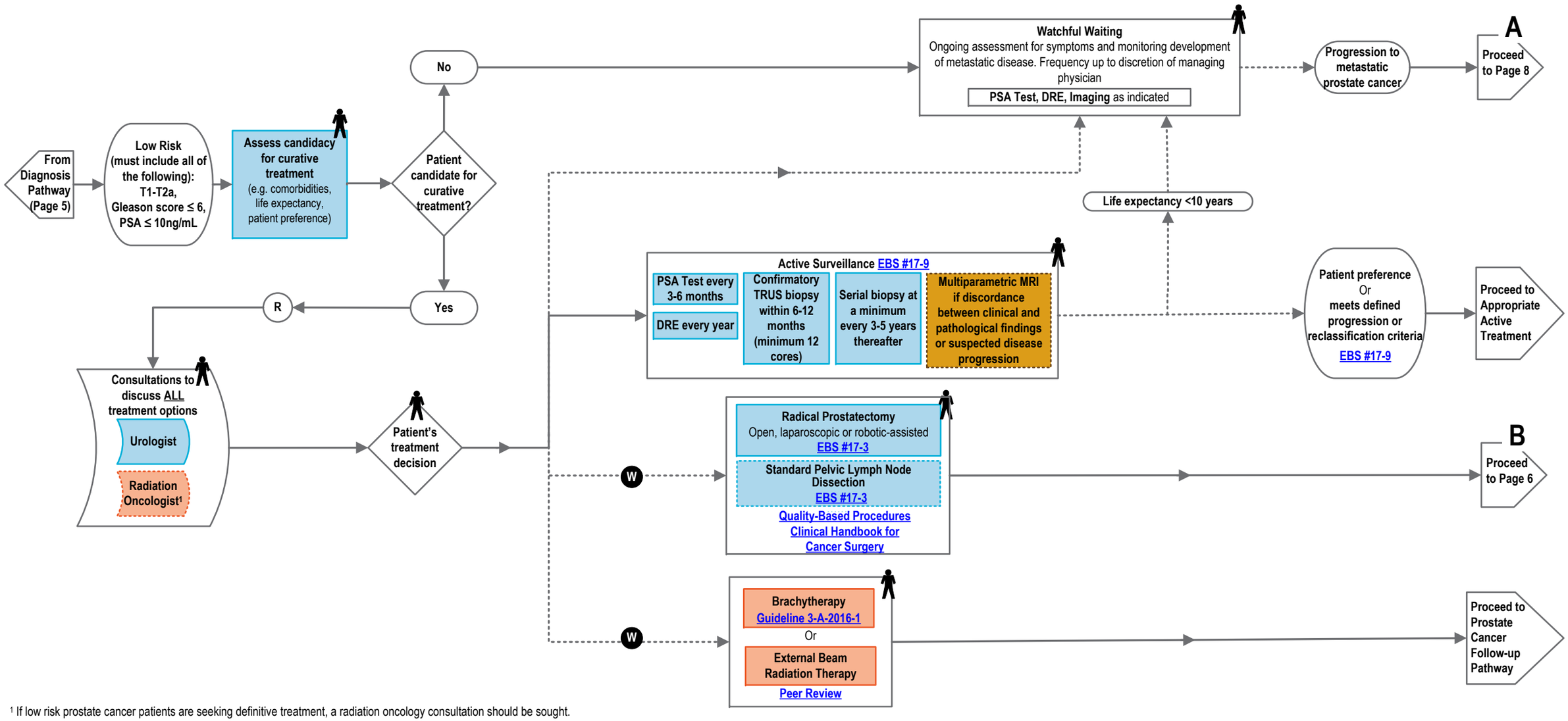
This pathway may not reflect all the available scientific research and is not intended as an exhaustive resource. CCO and its content providers assume no responsibility for omissions or incomplete information in this pathway. It is possible that other relevant scientific findings may have been reported since completion of this pathway. This pathway may be superseded by an updated pathway on the same topic.

**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] If low risk prostate cancer patients are seeking definitive treatment, a radiation oncology consultation should be sought.

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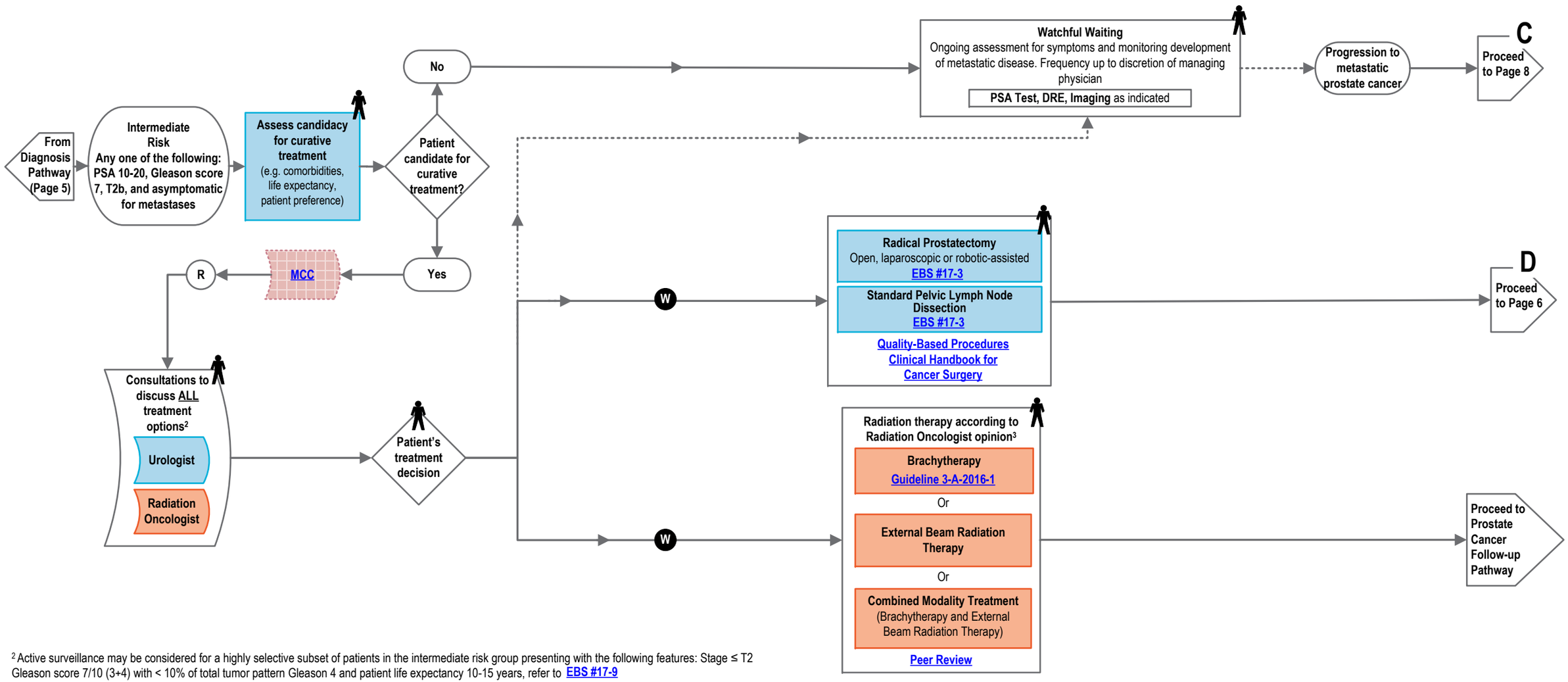


[2] Active surveillance may be considered for a highly selective subset of patients in the intermediate risk group presenting with the following features: Stage ≤ T2 Gleason score 7/10 (3+4) with < 10% of total tumor pattern Gleason 4 and patient life expectancy 10-15 years, refer to EBS #17-9

[3] Neoadjuvant/adjuvant androgen deprivation therapy can be considered for select patients.

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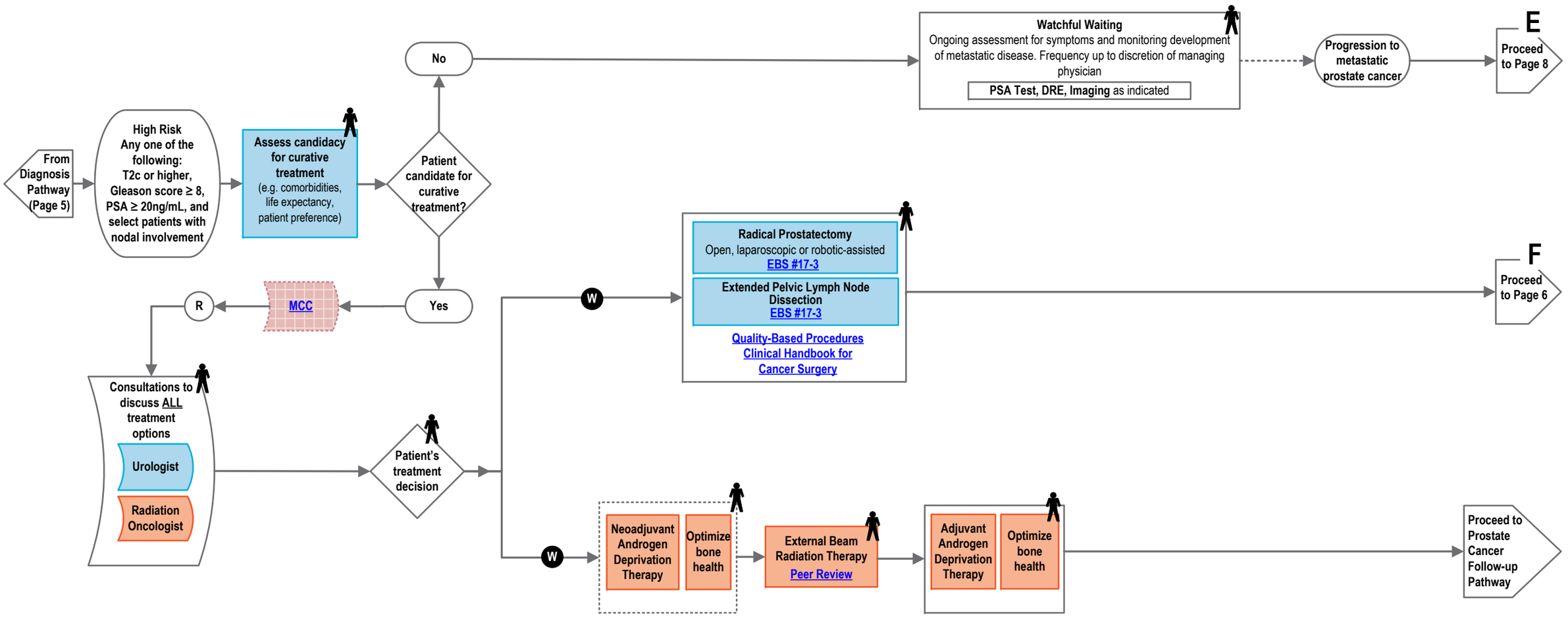

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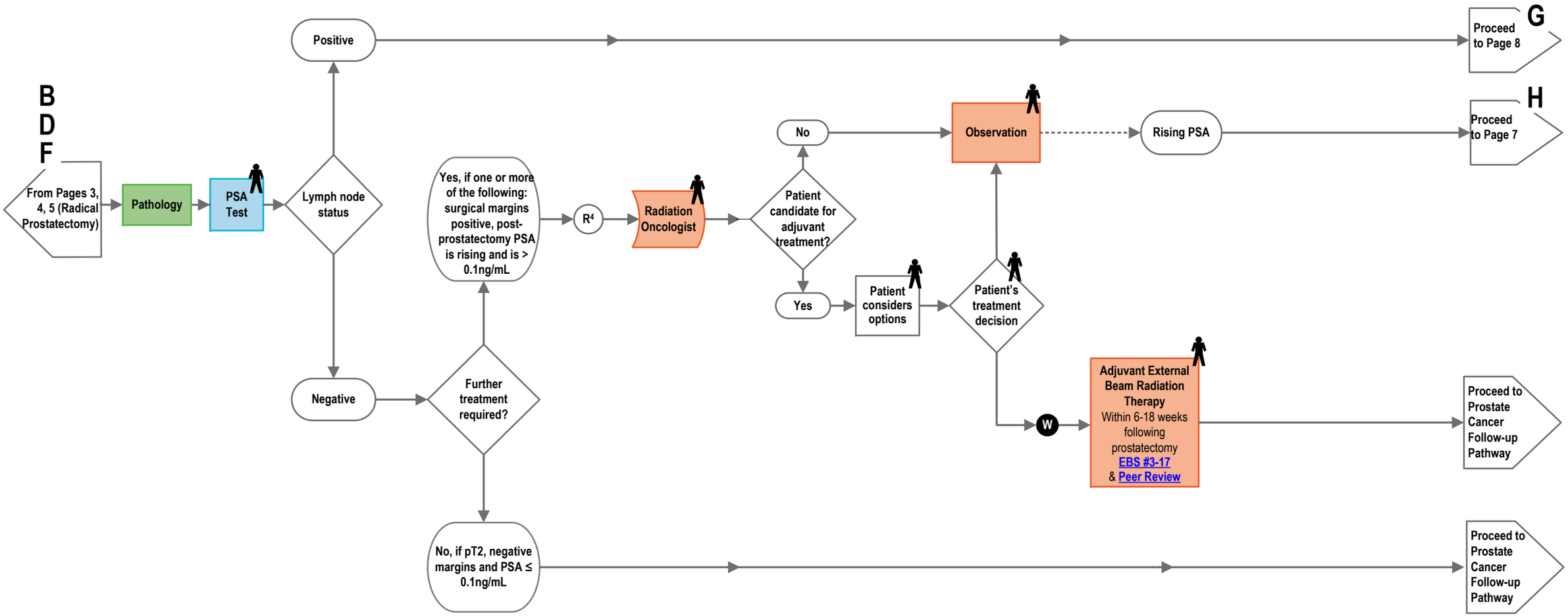


[4] Early referral recommended, **refer to** EBS #3-17 (This document is archived)

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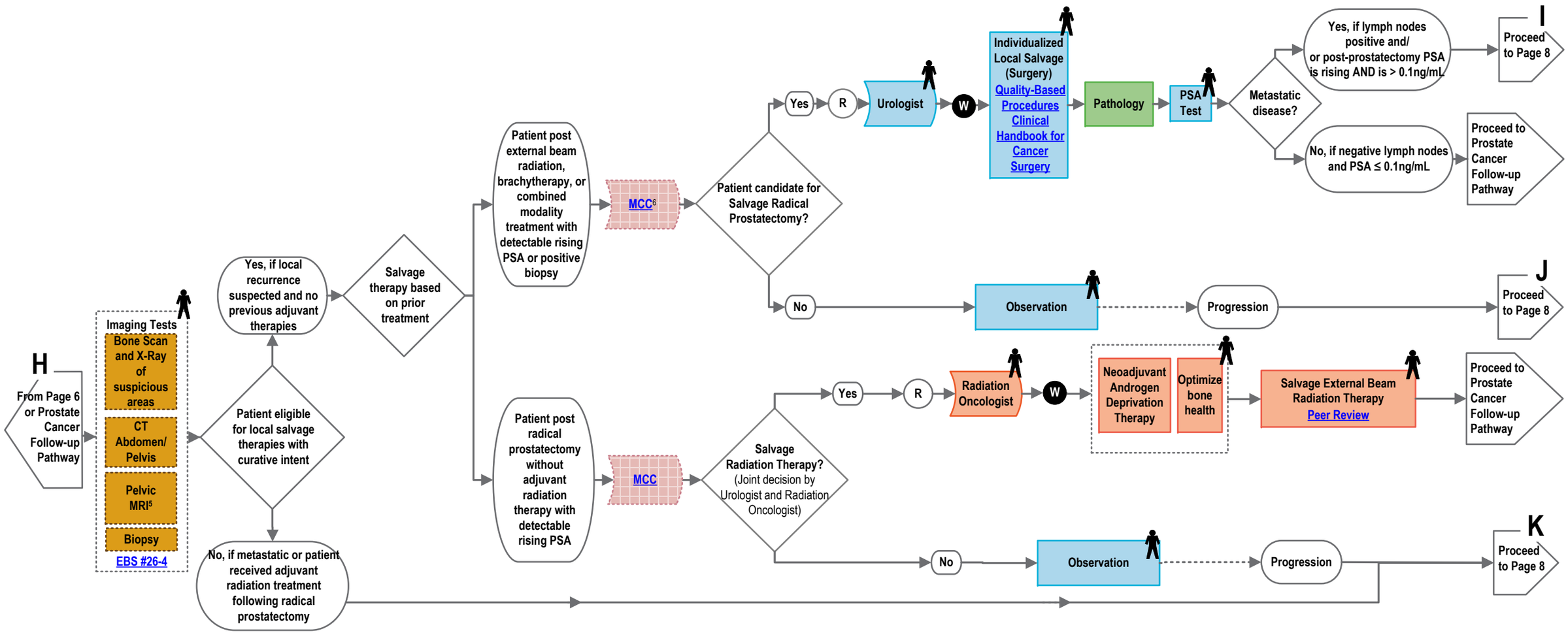


[5] MRI is appropriate when used for targeted biopsy

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

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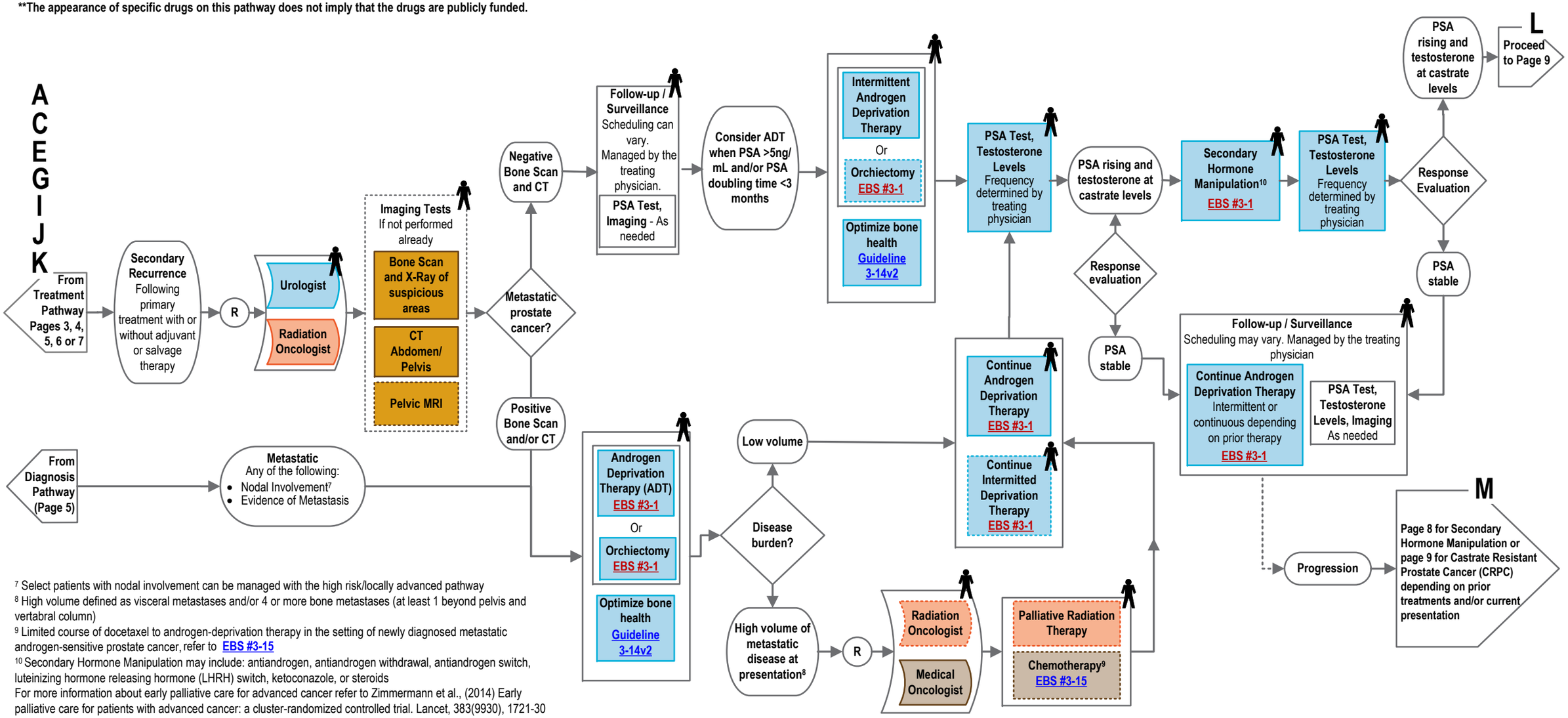
**Note: EBS #3-1** is older than 3 years and is currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes

****The appearance of specific drugs on this pathway does not imply that the drugs are publicly funded.**




[7] Select patients with nodal involvement can be managed with the high risk/locally advanced pathway

[8] High volume defined as visceral metastases and/or 4 or more bone metastases (at least 1 beyond pelvis and vertabral column)

[9] Limited course of docetaxel to androgen-deprivation therapy in the setting of newly diagnosed metastatic androgen-sensitive prostate cancer, refer to EBS #3-15

[10] Secondary Hormone Manipulation may include: antiandrogen, antiandrogen withdrawal, antiandrogen switch, luteinizing hormone releasing hormone (LHRH) switch, ketoconazole, or steroids

For more information about early palliative care for advanced cancer refer to Zimmermann et al., (2014) Early palliative care for patients with advanced cancer: a cluster-randomized controlled trial. Lancet, 383(9930), 1721-30

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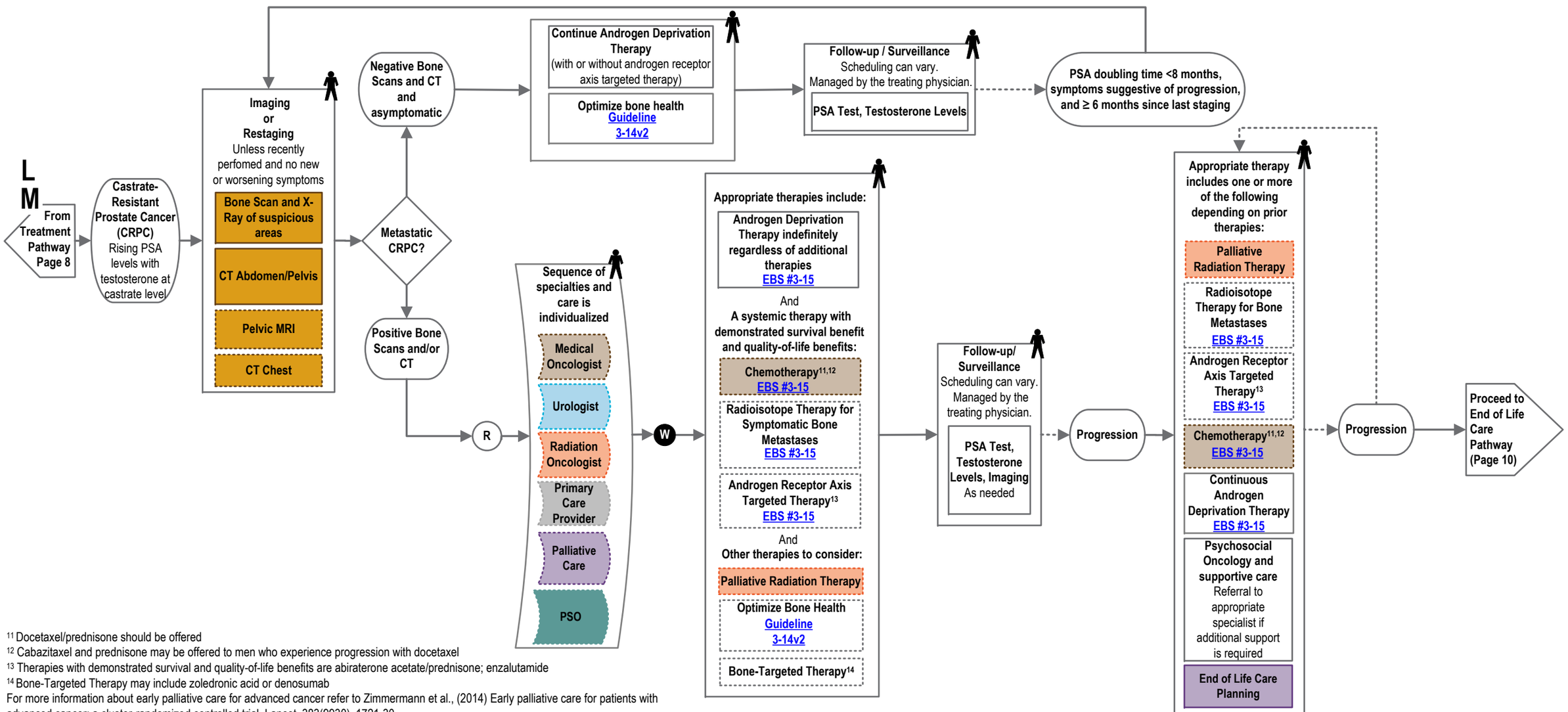


[11] Docetaxel/prednisone should be offered

[12] Cabazitaxel and prednisone may be offered to men who experience progression with docetaxel

[13] Therapies with demonstrated survival and quality-of-life benefits are abiraterone acetate/prednisone; enzalutamide

[14] Bone-Targeted Therapy may include zoledronic acid or denosumab

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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**

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**End of Life Care planning and implementation**
Collaboration and consultation between specialist-level care teams and primary care teams

## 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

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/