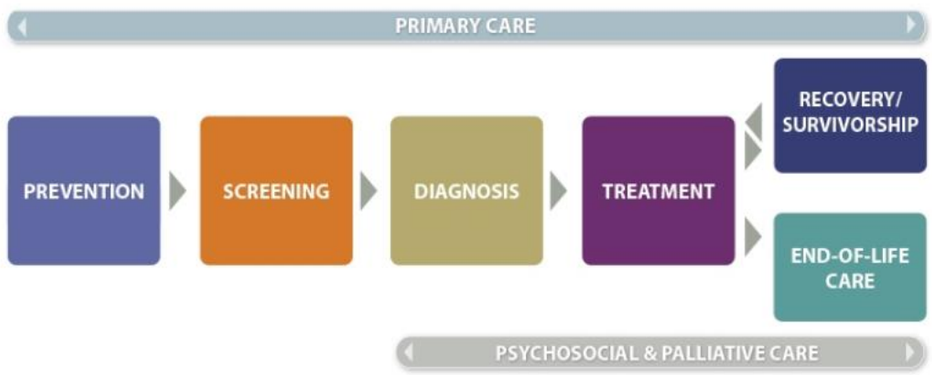
Cancer Care Ontario

Endometrial Cancer Treatment & Follow-Up Pathway Map

Disease Pathway Management

Version 2018.12



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 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 **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 'healthcare provider', used throughout the pathway map, includes primary care providers, 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

Colour Guide

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

Shape Guide

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

Line Guide

- Required
- Possible

Pathway Map Disclaimer

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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.

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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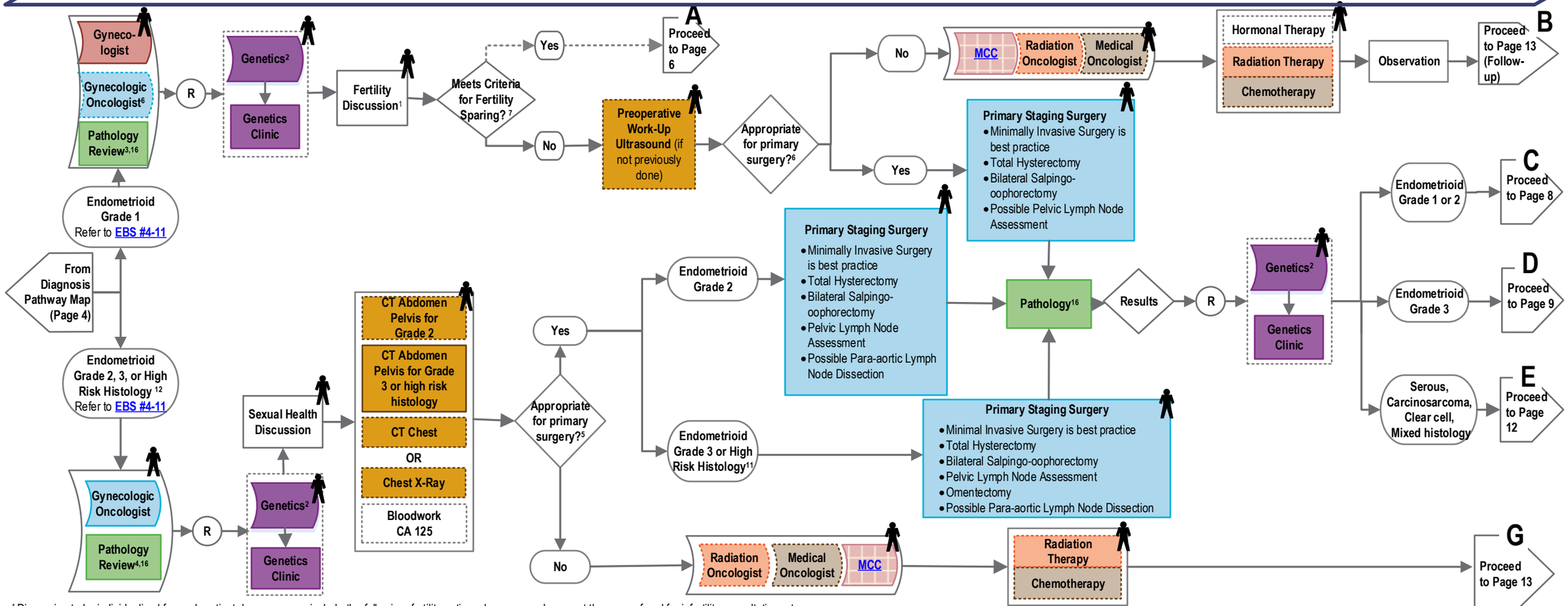

[1] Discussion to be individualized for each patient; however, may include the following: fertility options, hormone replacement therapy, referral for infertility consultation, etc.

[2] All tumours with MSH2/MSH6, MSH6, PMS2 and MLH1 (without hypermethylation) deficiency are candidates for genetic testing and should be referred for genetic counselling.

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

[4] 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)

[5] The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities

[6] 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

[7] Patients should undergo counseling that fertility sparing is for highly selected and motivated patients who meet strict criteria for progestin therapy. Criteria for fertility sparing 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.

[11] High risk histology: serous, clear cell, carcinosarcoma, undifferentiated, mixed high grade

[16] All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.

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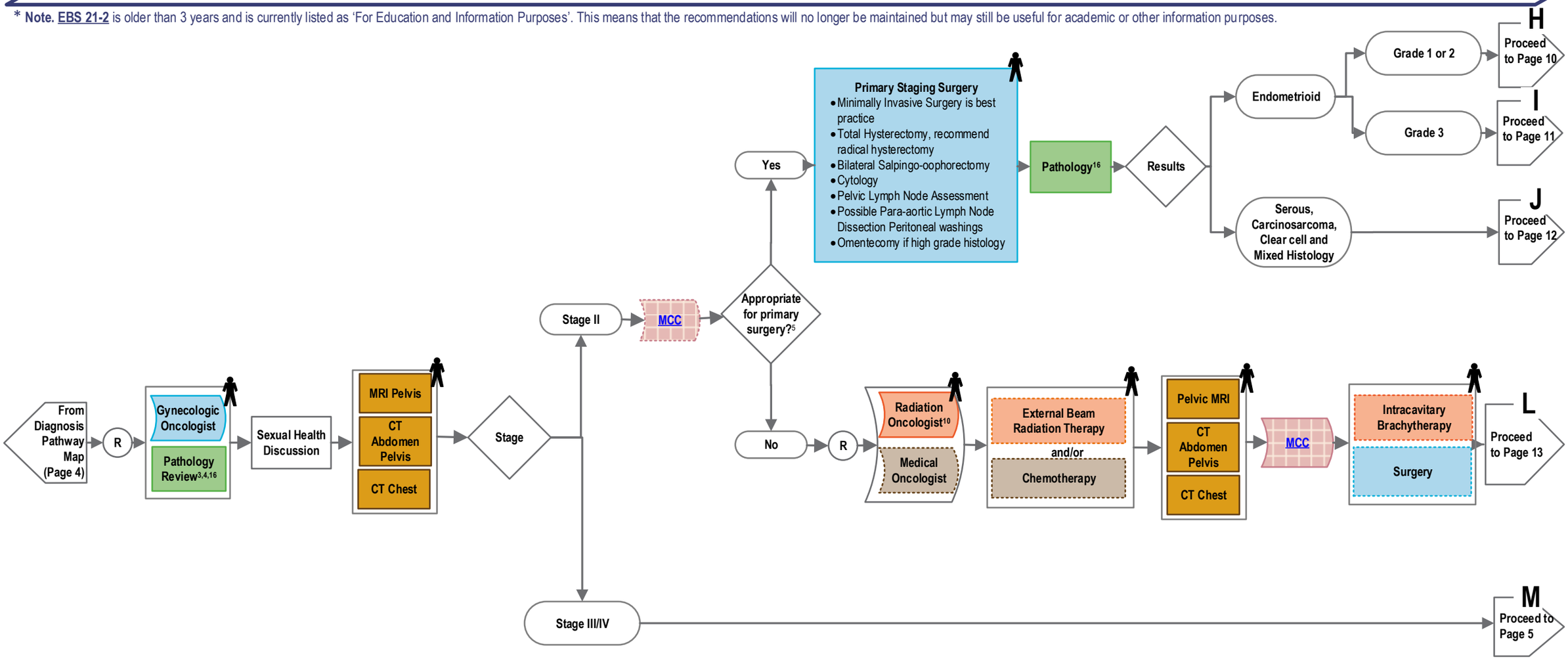

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[5] The following should be taken into consideration: performance status, surgical resectability, and patient comorbidities
[10] Consider referral to a radiation centre with intracavitary brachytherapy cases ≥ 10 per year EBS 4-11; EBS 21-2*
[16] All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.

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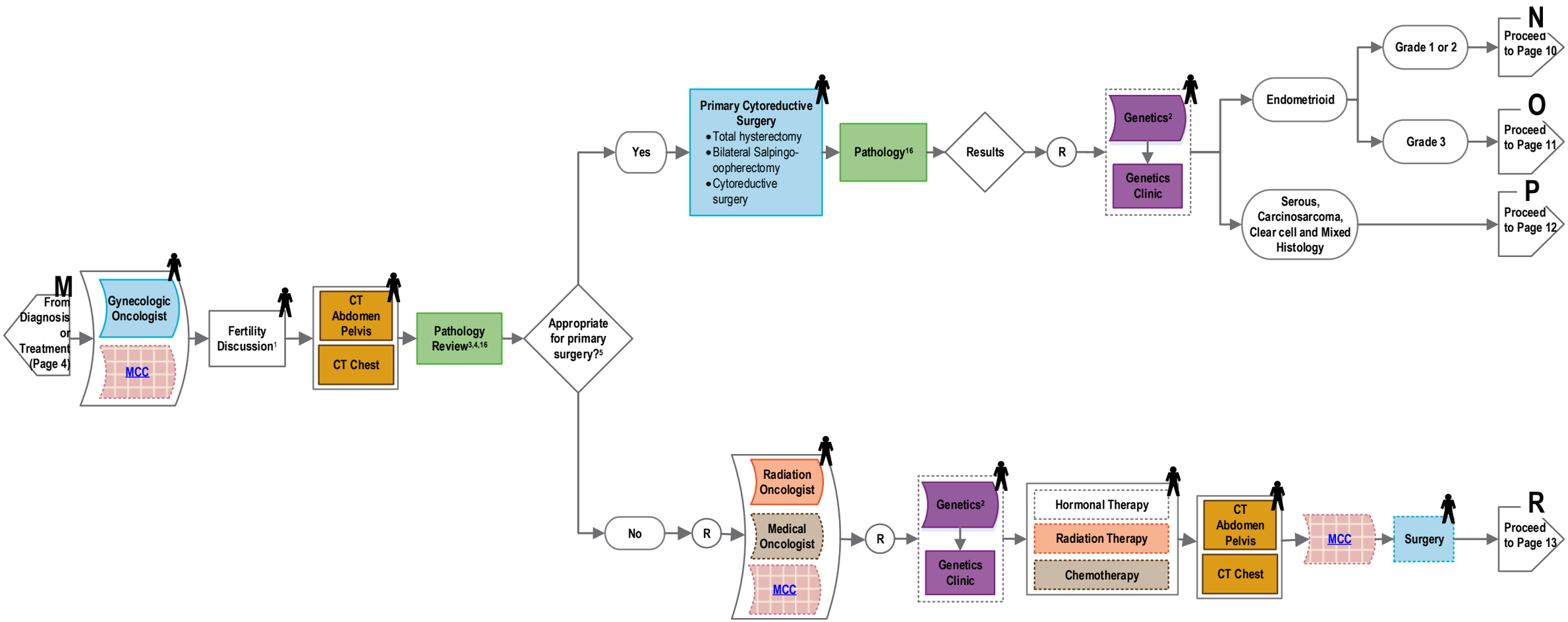

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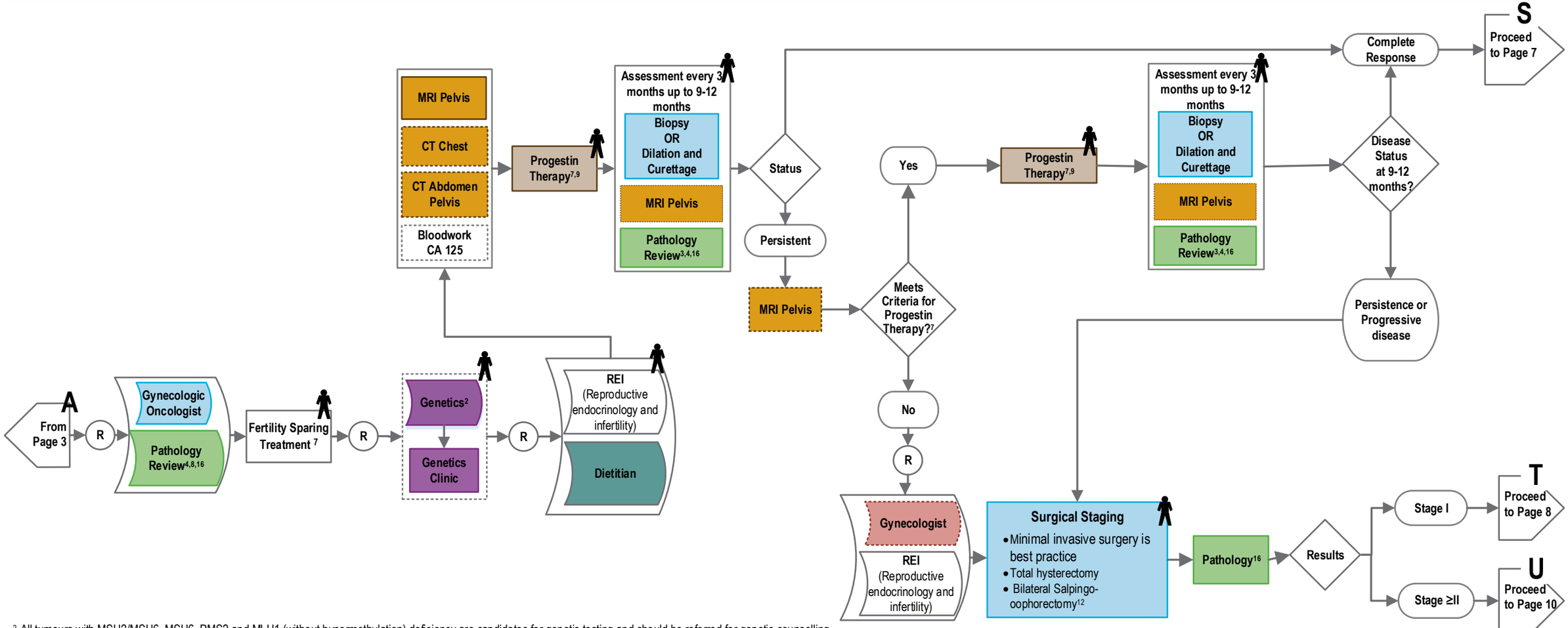

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[8] Consider requesting IHC for mismatch repair

[9] Suggested progestin therapy includes medroxyprogesterone, megestrol acetate, and levonorgestrel IUD

[12] Consider omitting oophorectomy after thorough preoperative counselling with patient

[16] All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.

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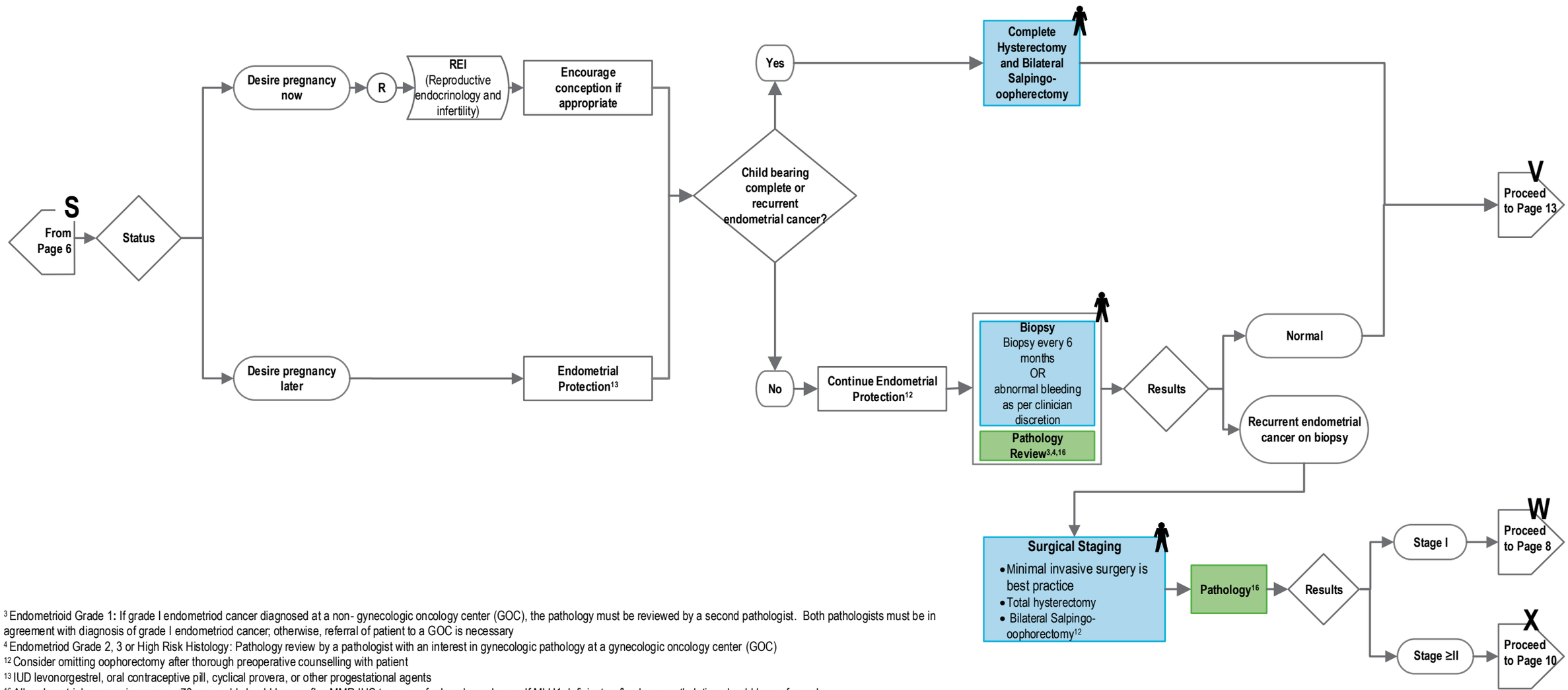

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[13] IUD levonorgestrel, oral contraceptive pill, cyclical provera, or other progestational agents

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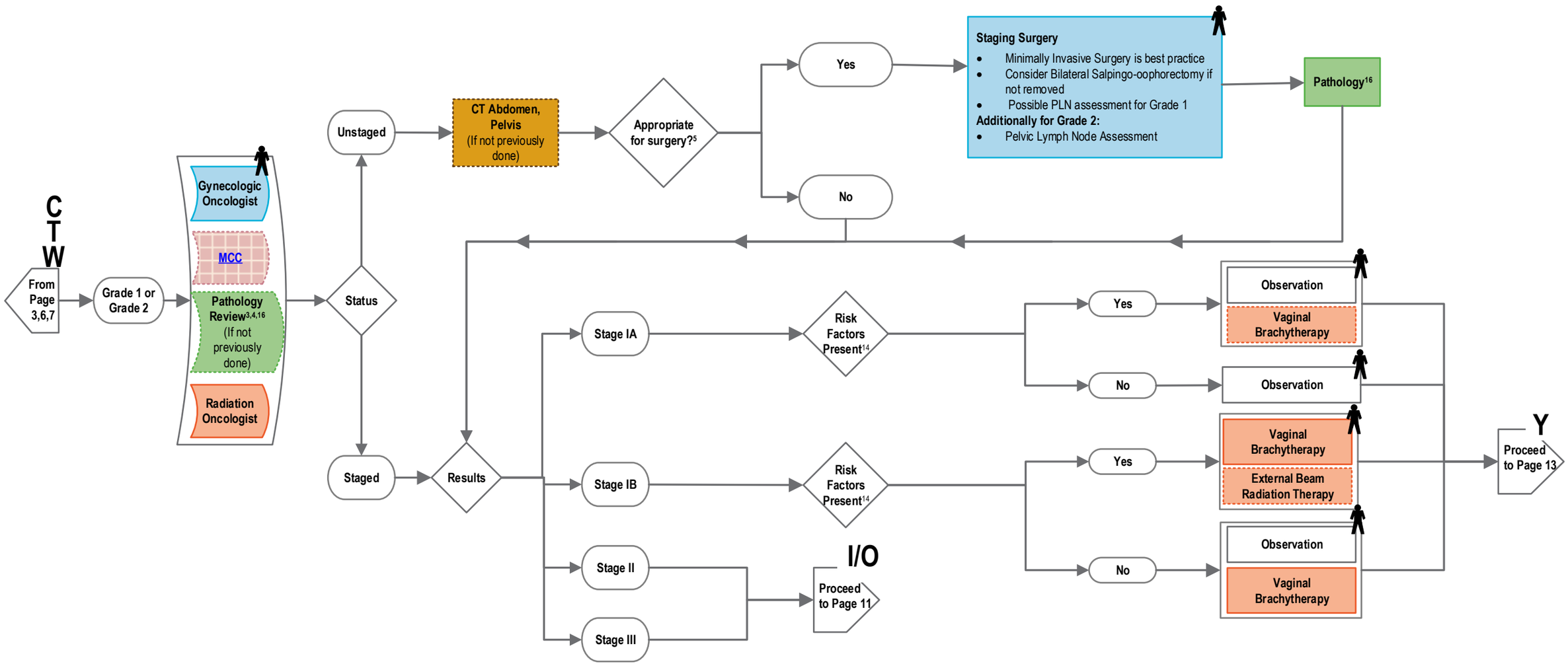

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[14] Risk factors include: age greater than 60 years based on Portec 1, positive lymphovascular invasion, deep myometrial invasion more than or equal to 50%
[16] All endometrial cancers in women <70 years old should have reflex MMR IHC to screen for Lynch syndrome. If MLH1 deficient, reflex hypermethylation should be performed.

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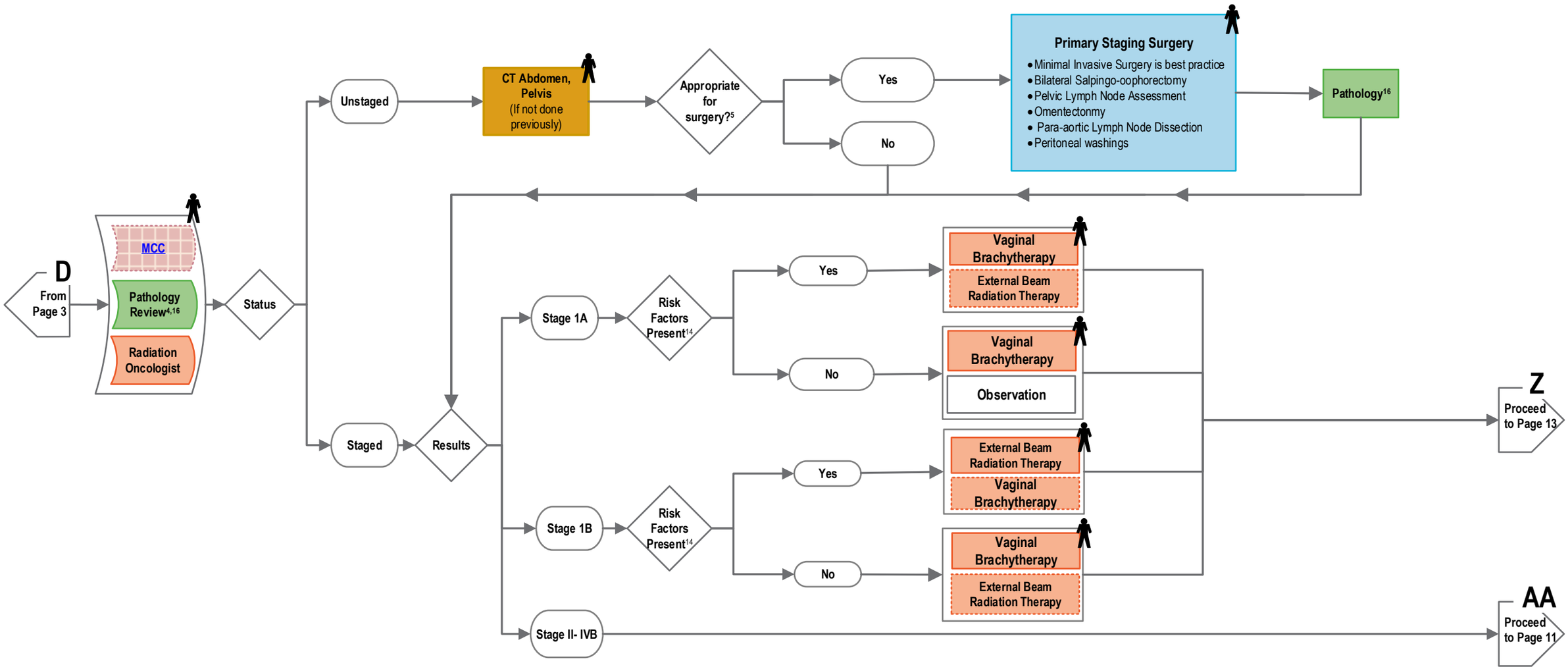

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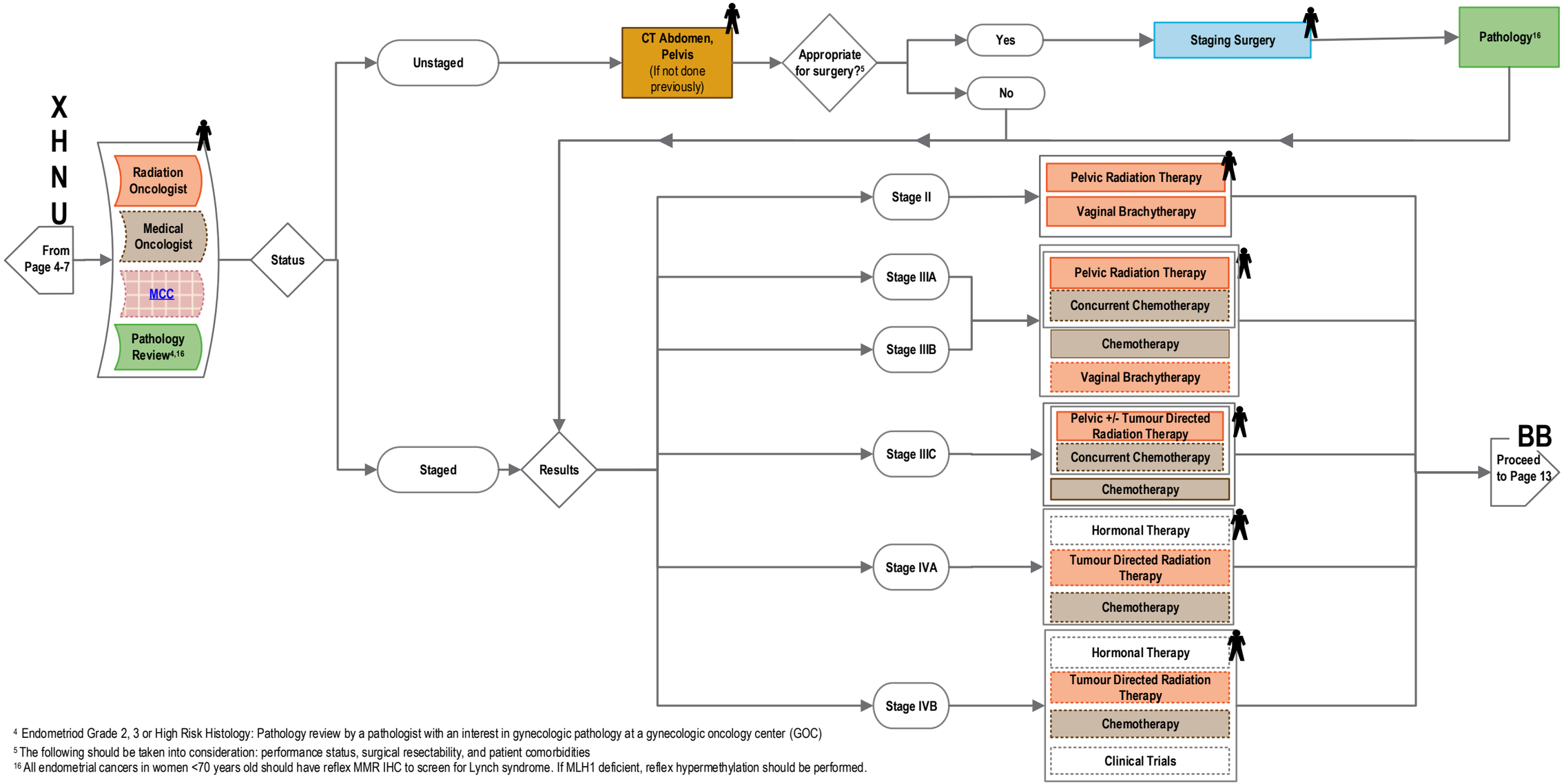

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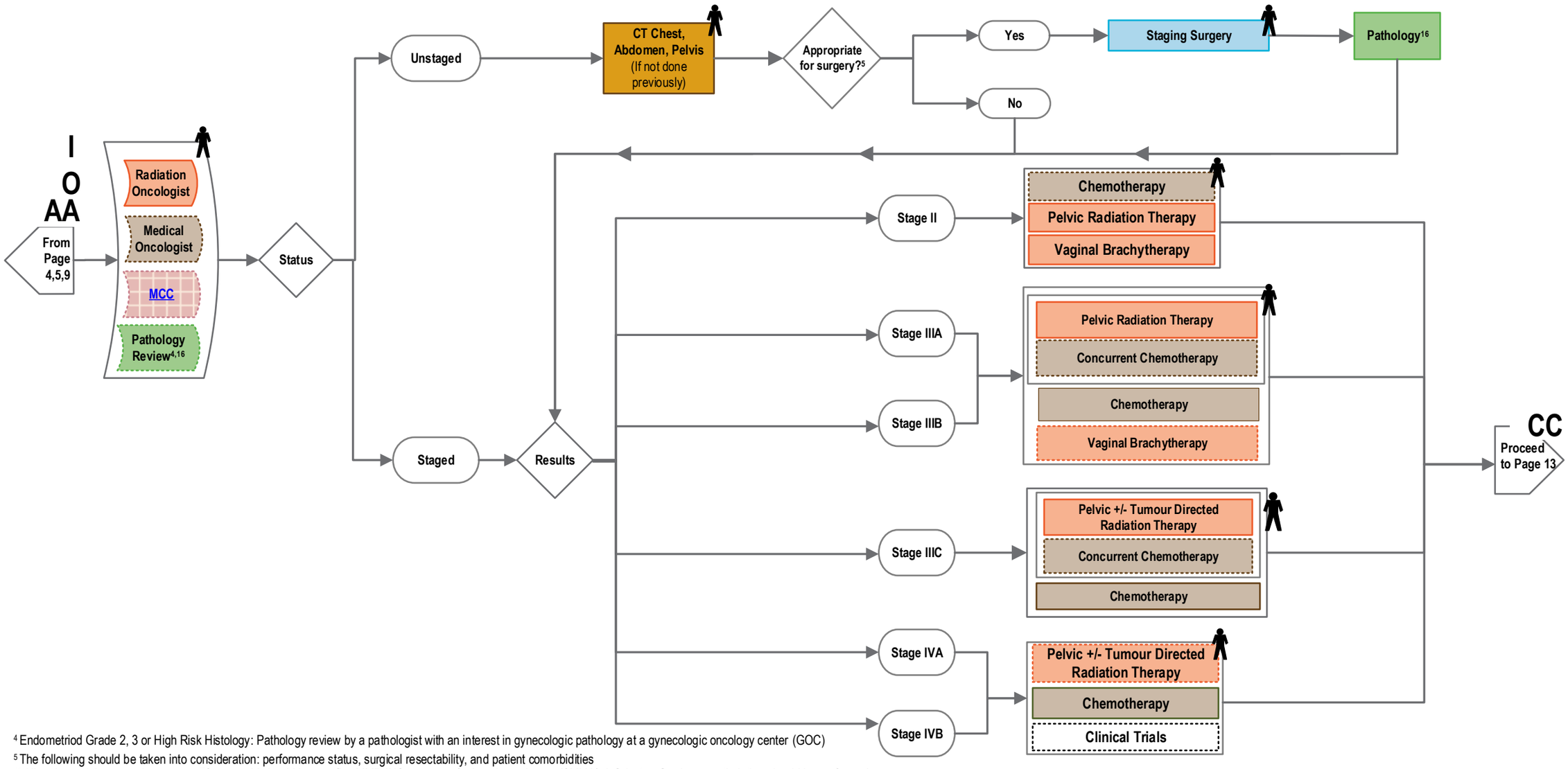

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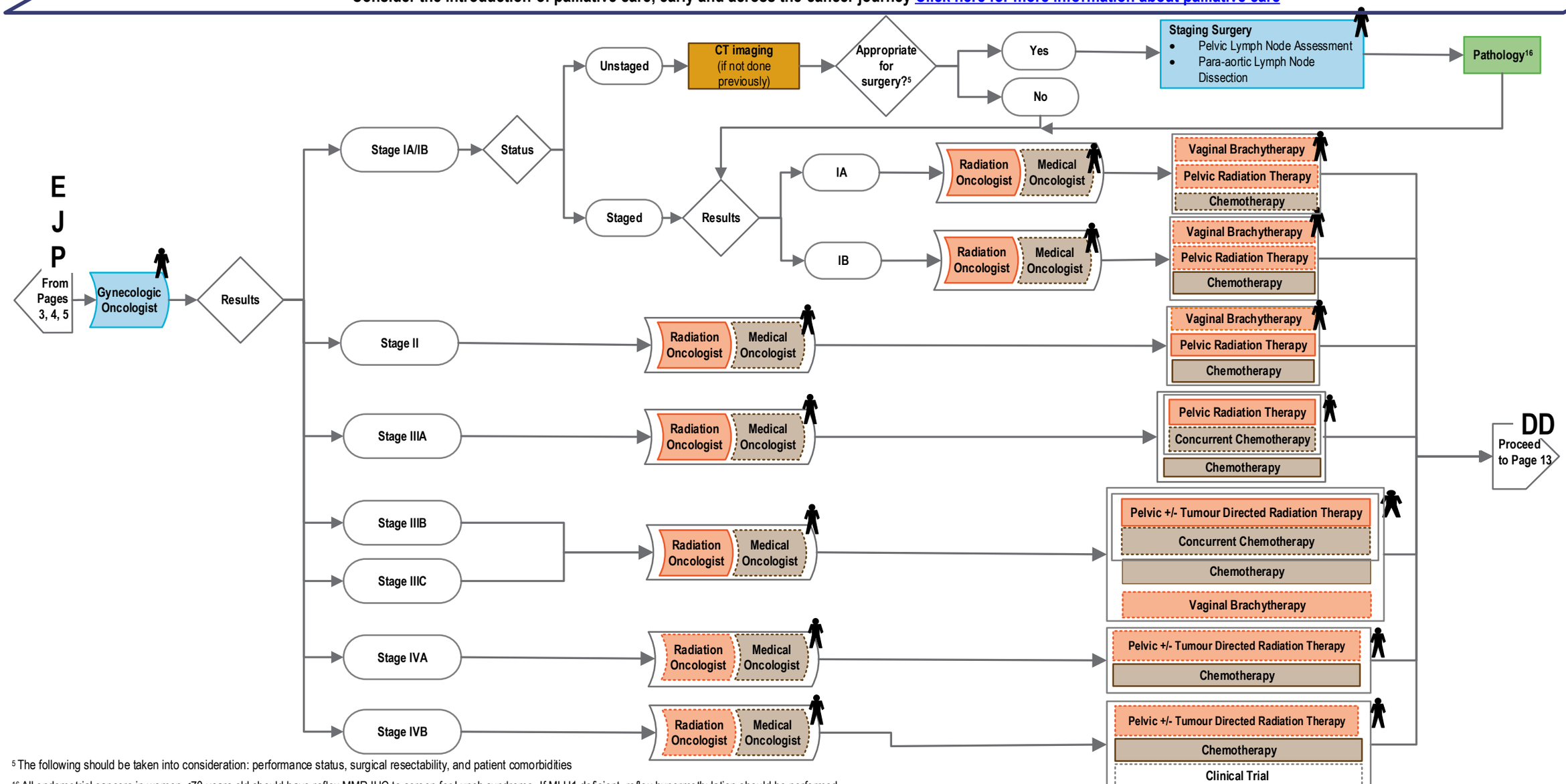

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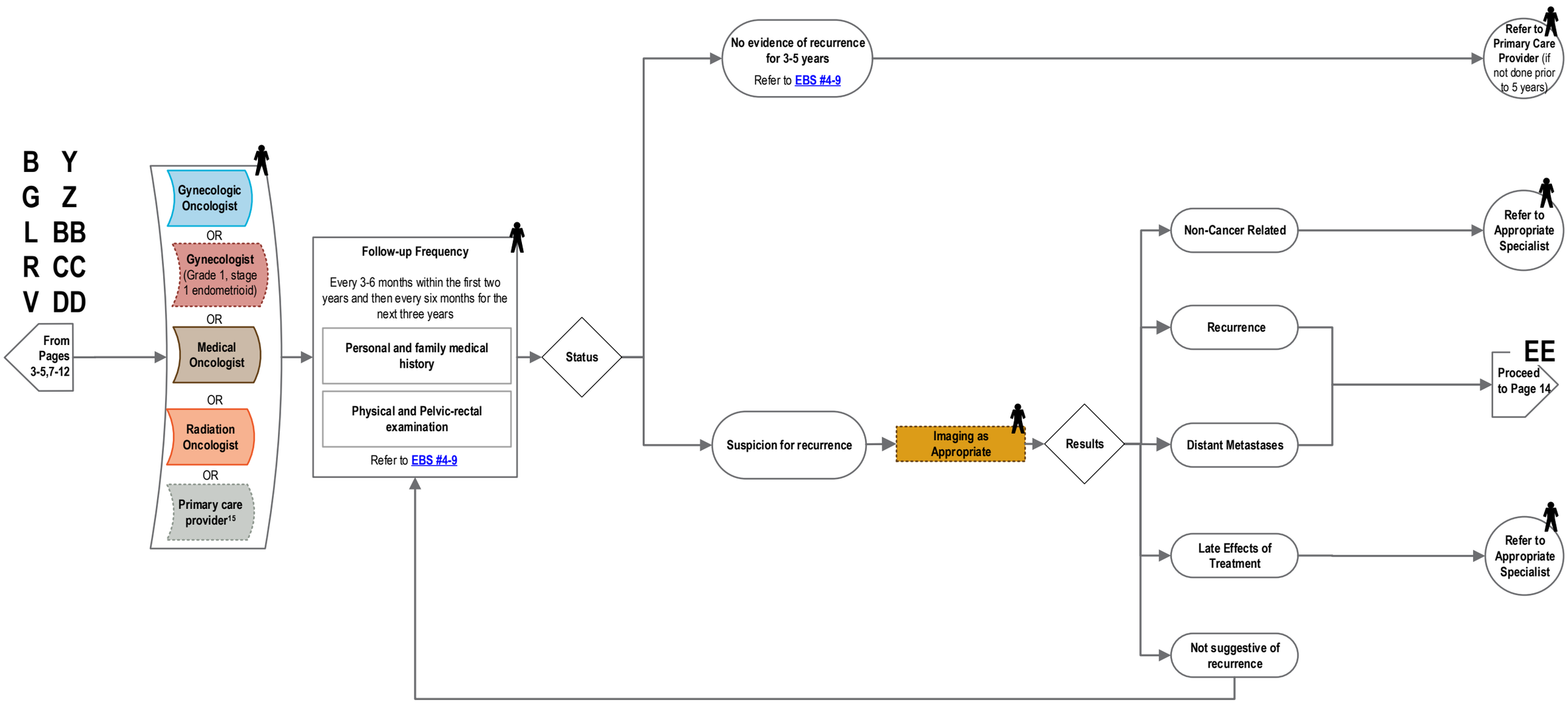

[15] Appropriate for low risk stage 1a with no adjuvant therapy

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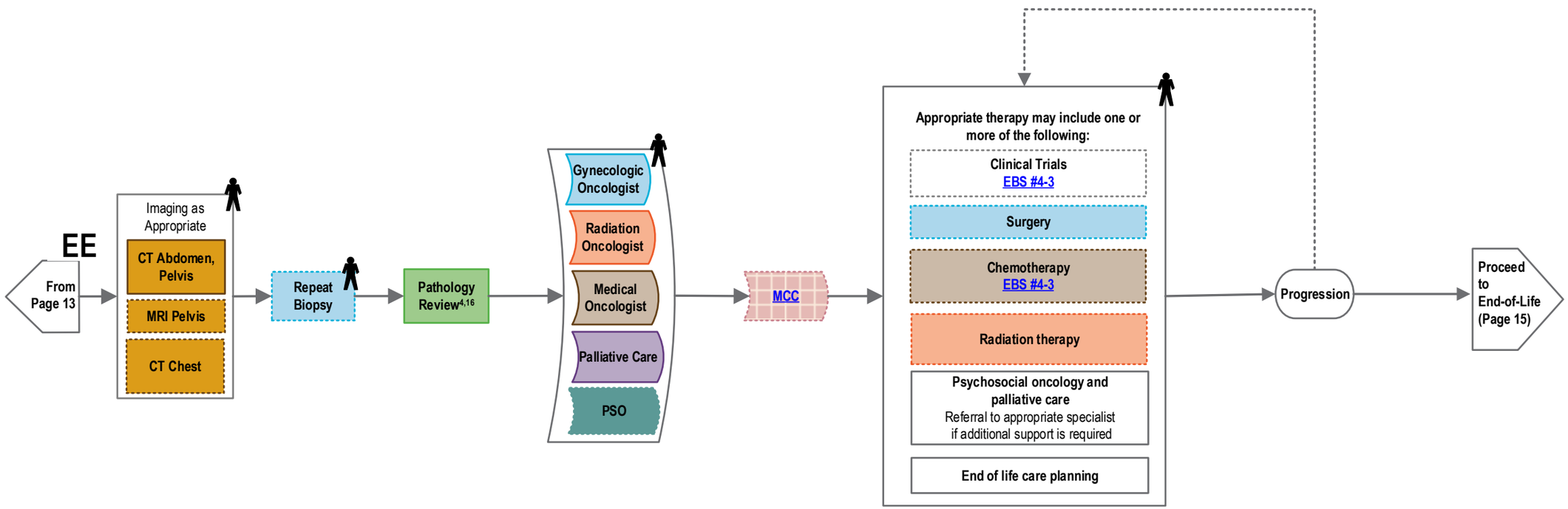

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Pathway Map Target Population:

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 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

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/

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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