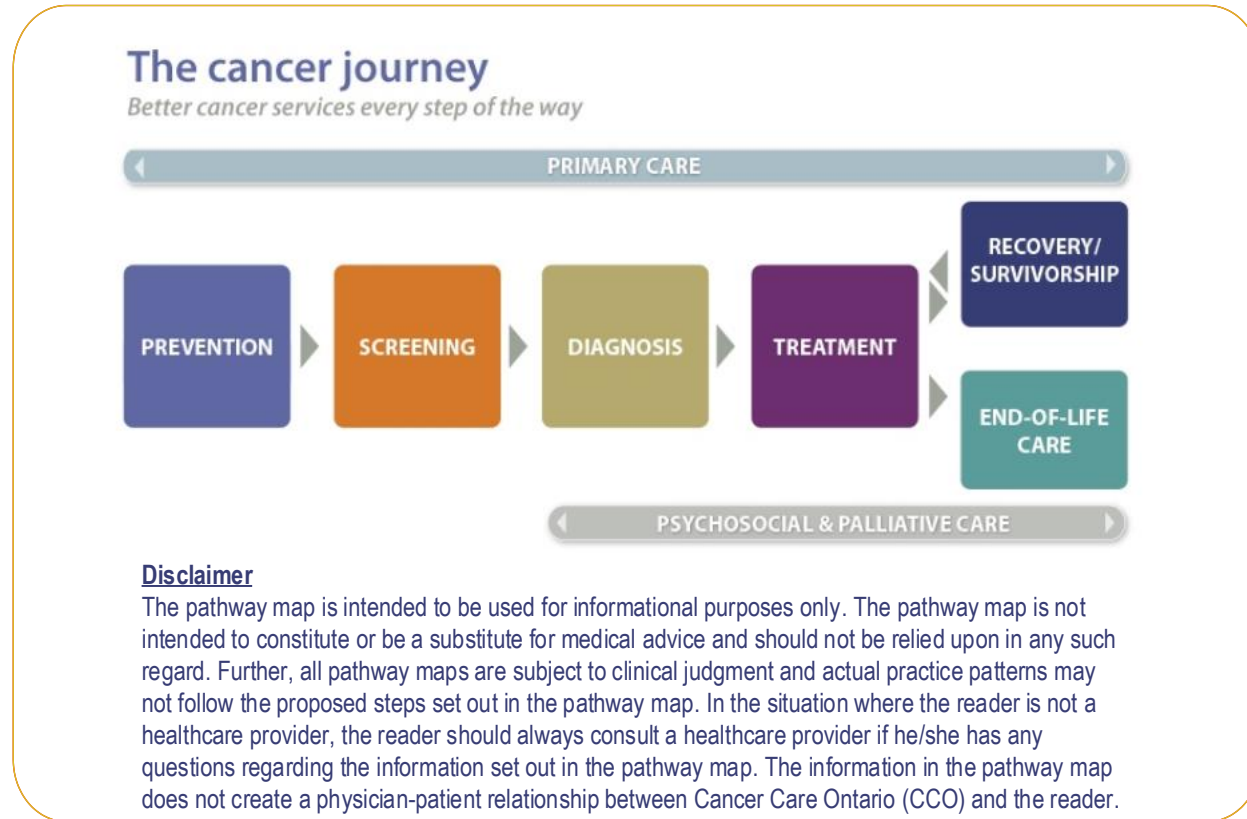


Esophageal Cancer Early Detection & Prevention Pathway Map

Version 2019.05



Target Population

Patients who present with signs or symptoms suspicious of Barrett’s esophagus.

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 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](#) and [EBS #19-2 Provider-Patient Communication*](#)
- 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, specialists, nurse practitioners, and emergency physicians.
- For more information on the Diagnostic Assessment Program (DAP) refer to the [Organizational Standards for DAPs](#)
- 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*](#)
- 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](#)

* **Note.** [EBS #19-2](#) and [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)
- Endoscopy/Gastroenterology
- 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 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.

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.

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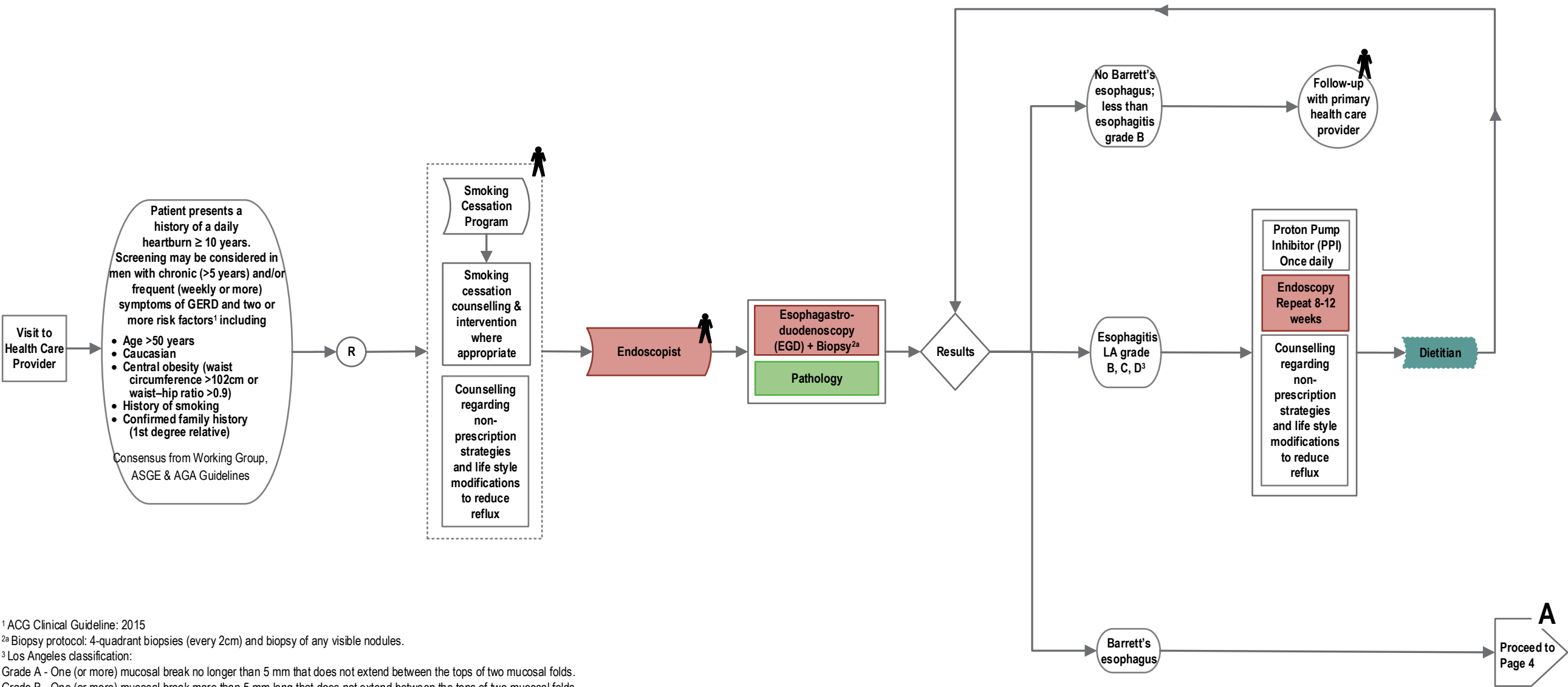
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Screen for psychosocial needs, and assessment and management of symptoms. [Click here for more information about symptom assessment and management tools](#)

Consider integrating the palliative care approach early and across the cancer journey. [Click here for more information about palliative care](#)



¹ ACG Clinical Guideline: 2015

^{2a} Biopsy protocol: 4-quadrant biopsies (every 2cm) and biopsy of any visible nodules.

³ Los Angeles classification:

Grade A - One (or more) mucosal break no longer than 5 mm that does not extend between the tops of two mucosal folds.

Grade B - One (or more) mucosal break more than 5 mm long that does not extend between the tops of two mucosal folds.

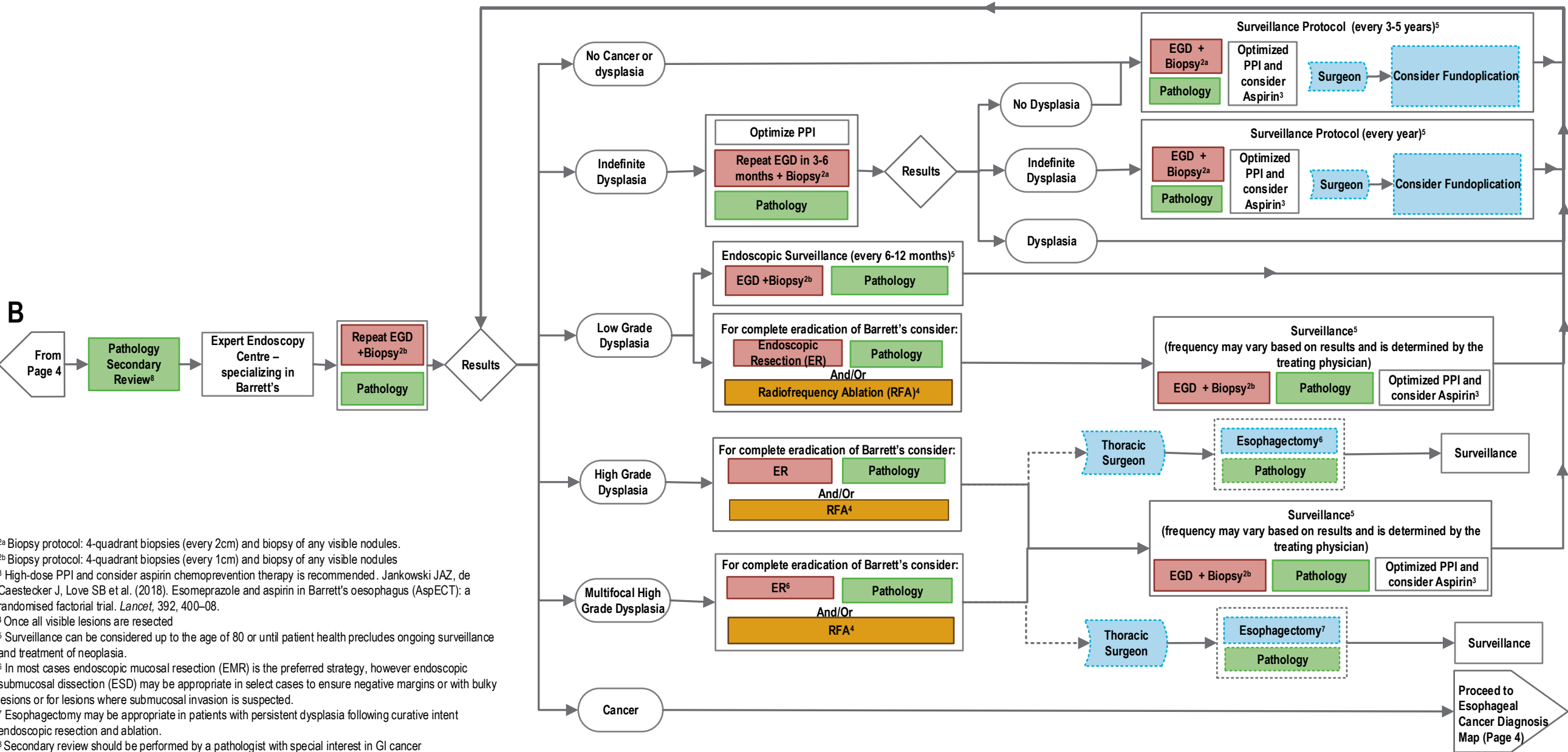
Grade C - One (or more) mucosal break that is continuous between the tops of two or more mucosal folds but which involves less than 75% of the circumference.

Grade D - One (or more) mucosal break which involves at least 75% of the oesophageal circumference.

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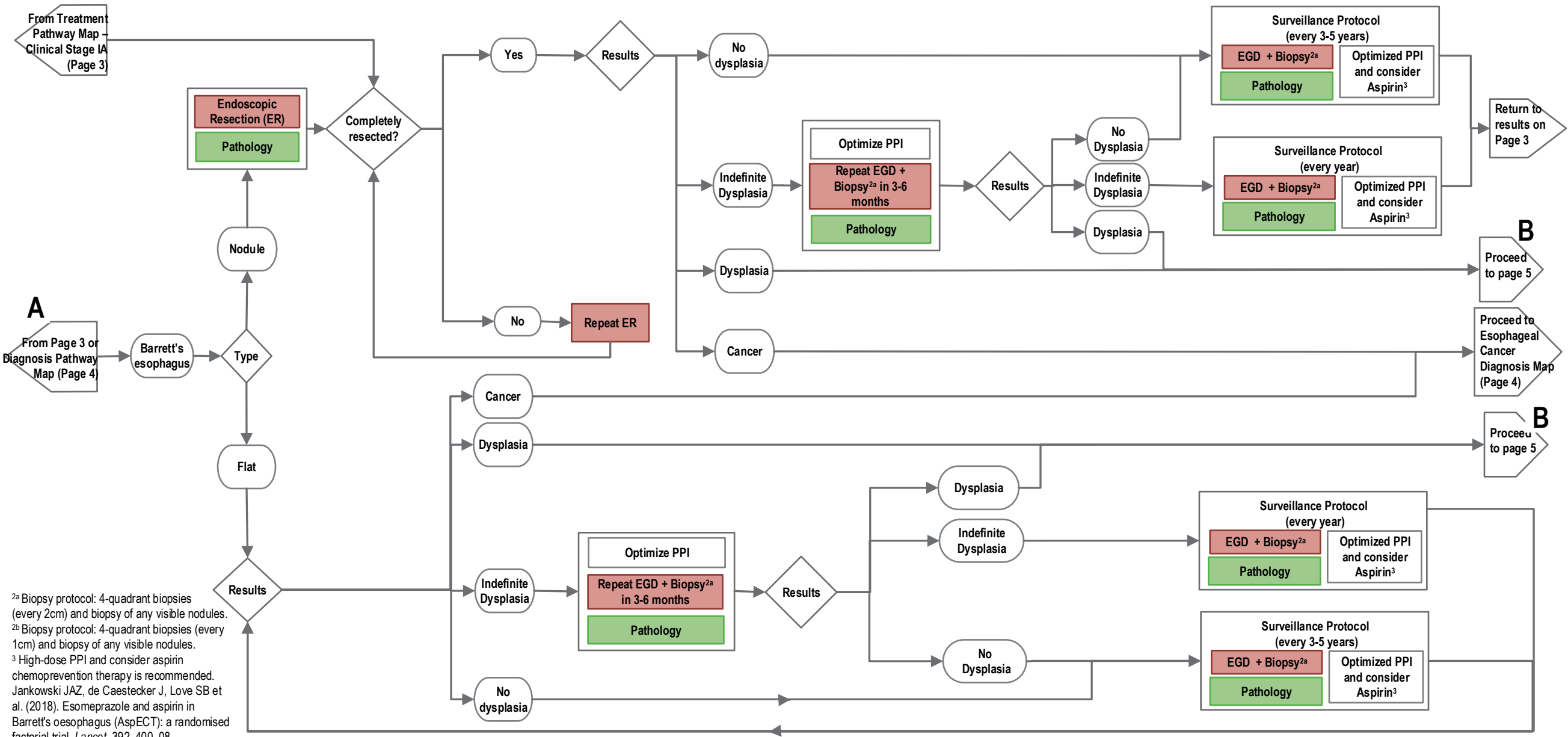


^{2a} Biopsy protocol: 4-quadrant biopsies (every 2cm) and biopsy of any visible nodules.
^{2b} Biopsy protocol: 4-quadrant biopsies (every 1cm) and biopsy of any visible nodules
³ High-dose PPI and consider aspirin chemoprevention therapy is recommended. Jankowski JAZ, de Caestecker J, Love SB et al. (2018). Esomeprazole and aspirin in Barrett's oesophagus (AspECT): a randomised factorial trial. *Lancet*, 392, 400–08.
⁴ Once all visible lesions are resected
⁵ Surveillance can be considered up to the age of 80 or until patient health precludes ongoing surveillance and treatment of neoplasia.
⁶ In most cases endoscopic mucosal resection (EMR) is the preferred strategy, however endoscopic submucosal dissection (ESD) may be appropriate in select cases to ensure negative margins or with bulky lesions or for lesions where submucosal invasion is suspected.
⁷ Esophagectomy may be appropriate in patients with persistent dysplasia following curative intent endoscopic resection and ablation.
⁸ Secondary review should be performed by a pathologist with special interest in GI cancer

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^{2a} Biopsy protocol: 4-quadrant biopsies (every 2cm) and biopsy of any visible nodules.

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