Esophageal Cancer Treatment Pathway Map
Version 2019.05

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 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 care for patients and their families at all stages of the illness trajectory. For more information, visit EBS #15-3.
- 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 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.*
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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.
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Stage IB & II

Adenocarcinoma

Stage II

T1 | N1 (M0) or
T2 | N0 (M0)

Squamous

Stage II

T2 | N0-N1 (M0) or
T3 | N0 (M0)

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From Diagnosis Pathway Map (Page 5)

Location of cancer

Stage II Neo-adjuvant Therapy EBS #2-11

Surgical Resection EBS #17-1

External Beam Radiation Therapy and/or
Brachytherapy and/or Systemic Therapy

Psychosocial oncology and supportive care
Referral to appropriate specialist if additional support is required

Nutritional support

Stent or Feeding tube

Endoscopy

Assess treatment response

CT Chest Abdomen Pelvis

PET: PET Recommendation Report 14

Assess treatment response

CT Chest Abdomen Pelvis OR PET: PET Recommendation Report 14

Pathology

Margins ± or Lymph Nodes

Positive MCC

Consider one or more of the following:

Surgical Resection EBS #17-1

Radiation therapy Peer Review

Nutritional support

Negative

Proceed to Follow-up Care Pathway Map

Follow

Esophagectomy EBS #17-1

Malignant Dysphagia Pathway Map (Page 10) &/or End of Life Care Pathway Map (Page 11)

End of Life care planning

Nutritional support

External Beam Radiation Therapy

and/or Brachytherapy

and/or Systemic Therapy

and/or Stent or Feeding tube

Gastroenterologist

Palliative Care

Endoscopist

Medical Oncologist

Definitive concurrent chemoradiation

Definitive concurrent chemoradiation

Radiation Oncologist

Thoracic Surgeon

Medical Oncologist

Definitive concurrent chemoradiation

Definitive concurrent chemoradiation

Nutritional support

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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PET is preferred.

Upper Gastroesophageal: 20 to 25 cm from upper central incisor teeth on endoscopy (EGD)

Mid Thoracic Esophagus: 25 to 35 cm from upper central incisor teeth on EGD

Lower Thoracic Esophagus: 30 cm or more to the GE junction.

1 PET is preferred.

4 Upper Thoracic Esophagus: 20 to 25 cm from upper central incisor teeth on endoscopy (EGD)

5 Mid Thoracic Esophagus: 25 to 35 cm from upper central incisor teeth on EGD

Lower Thoracic Esophagus: 30 cm or more to the GE junction.

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Clinical Stage IB and II
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For more information about early palliative care for advanced cancer refer to Zimmermann et al., (2014)
Esophageal Cancer Treatment Pathway Map

Clinical Stage III and IVA (adenocarcinoma)

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Stage III & IVA

Adenocarcinoma

Stage III

T2: N1 M0 or T3-T4a: N0-1 M0

Stage IVA

T1-4a: N2 M0 or T4b: N0-2 M0 or Any T1(N2) M0

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Concurrent Neoadjuvant Chemotherapy or Chemoradiation EBS #1-12

Reassessment of treatment response

CT Chest Abdomen Pelvis

PET (approximately 4 weeks post treatment)

PET Recommendation Report #4

Esophagectomy EBS #17-1

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Reconstructable or Potentially reconstructable

Resectable

Radiation therapy

Systemic therapy

Nutritional support

Reassess treatment response

CT Chest Abdomen Pelvis

PET (approximately 4 weeks post treatment)

PET Recommendation Report #4

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Unresectable patient declines surgery and good performance status

Unresectable and poor performance status

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Palliative Care6

PSO

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Palliative systemic therapy

Palliative External Beam Radiation Therapy

Palliative Brachytherapy

Nutritional support

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Psychosocial oncology and supportive care

Referral to specialist if additional support is required

End of life care planning

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Status

Unresectable

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Complete response

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If persistent or recurrent

Salvage Esophagectomy EBS #17-2

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Proceed to Malignant Dysphagia Pathway Map (Page 10) or Follow-up Care Pathway Map

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Proceed to Follow-up Care Pathway Map

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Proceed to Malignant Dysphagia Pathway Map (Page 10) &/or End of Life Care Pathway Map (Page 11)

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From Page 5

Adenocarcinoma

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PET is preferred.

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### Clinical Stage III and IVA (continued)

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#### Esophageal Cancer Treatment Pathway Map

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#### Esophageal Cancer Treatment Pathway Map

**Adenocarcinoma**

- Stage II: T2 N1 M0 or T3-T4a N0-N1 M0
- Stage IVA: T1-4a N2 M0 or T4b N0-2, M0 or Any T N3 M0

**Squamous**

- Stage II: T3 N1 M0 or T1-3 N2 M0
- Stage IVA: T4 N0-2 N1 M0 or Any T N3 M0

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**Stage III & IVA**

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

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

3. **External Beam Radiation Therapy**
   - and/or
   - Brachytherapy
   - and/or
   - Systemic Therapy

4. **Psychosocial oncology and supportive care**
   - Referral to appropriate specialist if additional support is required

5. **End of life care planning**
   - Manage Dysphagia (see page 9 Malignant Dysphagia Pathway)
   - Nutritional Support

**Adjuvant chemotherapy should be considered for patients who received neoadjuvant chemotherapy without concurrent radiation**
Esophageal Cancer Treatment Pathway Map

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**Stage IVB**

Any T  Any N  M1

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**Key factors to consider in treatment decision** include performance status, weight loss, disease symptoms, co-morbidities, sites of metastatic disease, molecular testing, patient wishes and understanding, and emotional status.

Review biomarker status

9

**Screening**

- Brachytherapy
- and/or
- External Beam Radiation Therapy
- and/or
- Systemic Therapy
- Psychosocial oncology and supportive care
- Referral to appropriate specialist if additional support is required
- End of life care planning
- Manage Dysphagia (see page 9 Malignant Dysphagia Pathway)
- Nutritional Support

**From Diagnosis Pathway Map (Page 5)**

R

**MCC 3,10**

**Palliative Care**

**Dietitian**

**Medical Oncologist**

**Radiation Oncologist**

**Referral to appropriate specialist if additional support is required**

**Proceed to Malignant Dysphagia Pathway (Page 10) &/or End of Life Care Pathway Map (Page 11)**

10

[Review biomarker status]
Esophageal Cancer Treatment Pathway Map

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**Type of recurrence**

- **Local luminal recurrence**
  - Consistent surgical and pathological confirmation (if not previously done)
  - **Biopsy**
  - **Pathology**
  - **Performance Status**
  - **Good**
    - **MCC**
    - **R**
    - **Medical Oncologist**
    - **Thoracic Surgeon**
    - **Radiation Oncologist**
  - **Poor**
    - **R**
    - **Palliative Care**
    - **PSO**

- **Local regional recurrence with nodal involvement**
  - **Biopsy**
  - **Pathology**
  - **Performance Status**
  - **Good**
    - **MCC**
    - **R**
    - **Medical Oncologist**
    - **Thoracic Surgeon**
    - **Radiation Oncologist**
  - **Poor**
    - **R**
    - **Palliative Care**
    - **PSO**

- **Distant recurrence**
  - **R**
  - **Medical Oncologist**
  - **Palliative Care**

**Appropriate treatment may include one or more of the following**

- **Surgical resection**
- **Radiation therapy**
- **Systemic therapy**
- **End of life care planning**
- **Nutritional Support**
- **Psychosocial oncology and supportive care**
  - Referral to appropriate specialist if additional support is required

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**Key**

- **R**: Review biomarker status
- **MCC**: 10, 11
- **PSO**: Palliative Support
- **Peer Review**

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10 Review biomarker status
11 Subsequent treatment depends on: performance status, time to relapse, age, patient wishes (if long disease-free interval, recurrent tumor may be sensitive to initial chemotherapy)
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### 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 2-4 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

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**Esophageal Cancer Treatment Pathway Map**

**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.

- **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

### 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

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**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/](http://www.goldstandardsframework.org.uk/)
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