Non-small Cell Lung Cancer Treatment Pathway Map

Pathway Map Preamble

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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 Ontario Health (Cancer Care Ontario) and the reader.

Target Population

- Patients with a confirmed non-small cell lung cancer diagnosis who have undergone the recommended diagnostic and staging procedures as outlined in the Lung Cancer Diagnosis Pathway Map.

Pathway Map Considerations

- Any disease site-specific information that applies throughout the pathway map can go at the top of the Considerations. The following text is boilerplate and should be mostly uniform across all pathway maps, though there may be some variation.
- 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 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 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.*

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.

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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 the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care.

Non-small Cell Lung Cancer Treatment Pathway Map

Clinical stage IA and IB

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Stage I

Stage IA
T1 | N0 | M0

Stage IAI
T1 Mi | N0 | M0

Stage IAI
T1b | N0 | M0

Stage IAI
T1c | N0 | M0

Stage IB
T2a | N0 | M0

AJCC Cancer Staging Manual 8th edition

Resectable and medically operable

Resectable and medically operable

Surgical resection

EBS #17-1

Pathology

Results

Resectable and medically operable

Pathological stage IIIA

Margins negative, Stage IA

Medical Oncologist

Systemic Therapy

GL-7-A-2016-3

Resectable

Pathological stage I

Margins positive, All stage I

Medical Oncologist

Systemic Therapy

Considered only for stage IB

GL-7-A-2016-3

Not resectable

Thoracic Surgeon

reassesment

J

From Page 8 Or From Diagnosis Pathway Map (Page 7)

Unresectable or medically inoperable or patient declines surgery

Thoracic Surgeon

Interventional Radiologist

Radical radiation therapy

Curative intent (Stereotactic body radiation therapy or standard fractionation radiotherapy)

Peer Review Or EBS #7-21

Focal Tumour Ablation

Summary of Recommendations

For more information about biomarkers, refer to the Lung Cancer Tissue Pathway.

Tumour ablation may be considered if not eligible for other treatment.

Proceed to stage appropriate treatment pathway map

Proceed to stage appropriate treatment pathway map

Proceed to Follow-up Care Pathway Map (Page 3)

Proceed to Follow-up Care Pathway Map (Page 3)

Proceed to Follow-up Care Pathway Map (Page 3)

Proceed to Follow-up Care Pathway Map (Page 3)
Clinical stage IIA and IIB

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For more information about biomarkers, refer to the Lung Cancer Tissue Pathway
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Clinical stage IIA and IIB contd

Non-small Cell Lung Cancer Treatment Pathway Map

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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C

Margins negative

Margins positive

From

Pathology

MCC

Results

Positive

Nodes

Negative

Nodes

Adjuvant systemic therapy

GL-7-A-2016-3

Individualized treatment plan based on previous interventions and treatments

Radiation Oncologist

Medical Oncologist

Thoracic Surgeon

Proceed to Follow-up Care Pathway Map (Page 3)

From Page 4

Results

1 For more information about biomarkers, refer to the Lung Cancer Tissue Pathway
Non-small Cell Lung Cancer Treatment Pathway Map

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1 For more information about biomarkers, refer to the Lung Cancer Tissue Pathway.

2 Managing physician may be a surgeon, respirologist or radiation oncologist.


4 Includes T3 N1 M0, T4 N0 or N1 M0, T2/T2 N2 only if single station intracapsular N2

Clinical stage IIIA and IIB

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Non-small Cell Lung Cancer Treatment Pathway Map

Stage IV (No CNS Metastases)

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Stage IV

No CNS Metastases

Stage IV

Any T | Any N | M1

Stage IVA

Any T | Any N | M1a, b

Stage IVB

Any T | Any N | M1c

AJCC Cancer Staging Manual 8th edition

Stage IV

Good/mode performance status (ECOG 0 to 2 or PPS 100 and/or localized symptomatic disease)

Radiation therapy

Systemic therapy

EBS #7-10

Stage IVB

Severe localized disease amenable to radiation or Focal Tumour Ablation

Radiation therapy

Focal Tumour Ablation Summary of Recommendations

Systemic therapy

EBS #7-10

Poor performance status

ECOG 3 PPS 40-50

Focal Tumour Ablation Summary of Recommendations

Consider targeted therapy if mutation positive

Palliative radiation therapy

ECOG 4 PPS 10-30

Psychosocial oncology and supportive care

Therapy with palliative intent

MCC 7, 8

Therapy may include chemotherapy, radiation, surgery, etc.

Consider targeted therapy if mutation positive

Psychosocial oncology and supportive care

Referral to appropriate specialist if additional support is required

End of life care planning

E G I

From Diagnosis Pathway Map (Page 7)

Managing Physician

Medical Oncologist

Radiation Oncologist

Interventional Radiologist

Palliative Care

PSO

From Page 6 or 8 or 9

Patient is usually managed by a medical oncologist.

Key factors to consider in treatment decisions include performance status, weight loss, disease symptoms, comorbidities, sites of metastatic disease, molecular testing, patient wishes and understanding, and emotional status.

Review biomarker status

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

End of life care planning

Proceed to End of Life Care Pathway Map (Page 10)
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Stage IV (CNS Metastases) Non-small Cell Lung Cancer Treatment Pathway Map

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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 the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care

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6 Patient is usually managed by a medical oncologist.
7 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.
8 If small and asymptomatic brain metastases, consider deferring radiation therapy and initiating systemic therapy. These patients require close surveillance that should include surveillance of physical and emotional symptoms.
9 Radiation oncologist with CNS expertise or one who treats brain metastases
Non-small Cell Lung Cancer Treatment Pathway Map

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Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care

Appropriate treatment may include one or more of the following:
- Radiation therapy
- Systemic therapy

Performance Status
- Good
- Poor

Type of Recurrence
- Local regional recurrence
- Distant recurrence

CNS metastasis

Pathological Confirmation (if not previously done)
- Biopsy
- Pathology

End of Life Care Planning
- Systemic therapy
- Radiation therapy

End of Life Care Planning
- Systemic therapy
- Radiation therapy

Screen for psychosocial needs, and assessment and management of symptoms.

Consider the introduction of palliative care, early and across the cancer journey.

End of Life Care Planning
- Systemic therapy
- Radiation therapy

Review biomarker status

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)

Performance Status
- Good
- Poor

Palliative Care

Appropriate treatment may include one or more of the following:
- Radiation therapy
- Systemic therapy
- Surgical resection
- Focal Tumor Ablation

Referral to appropriate specialist if additional support is required
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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/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

End of Life Care

- 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

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.
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

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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End of Life Care contd