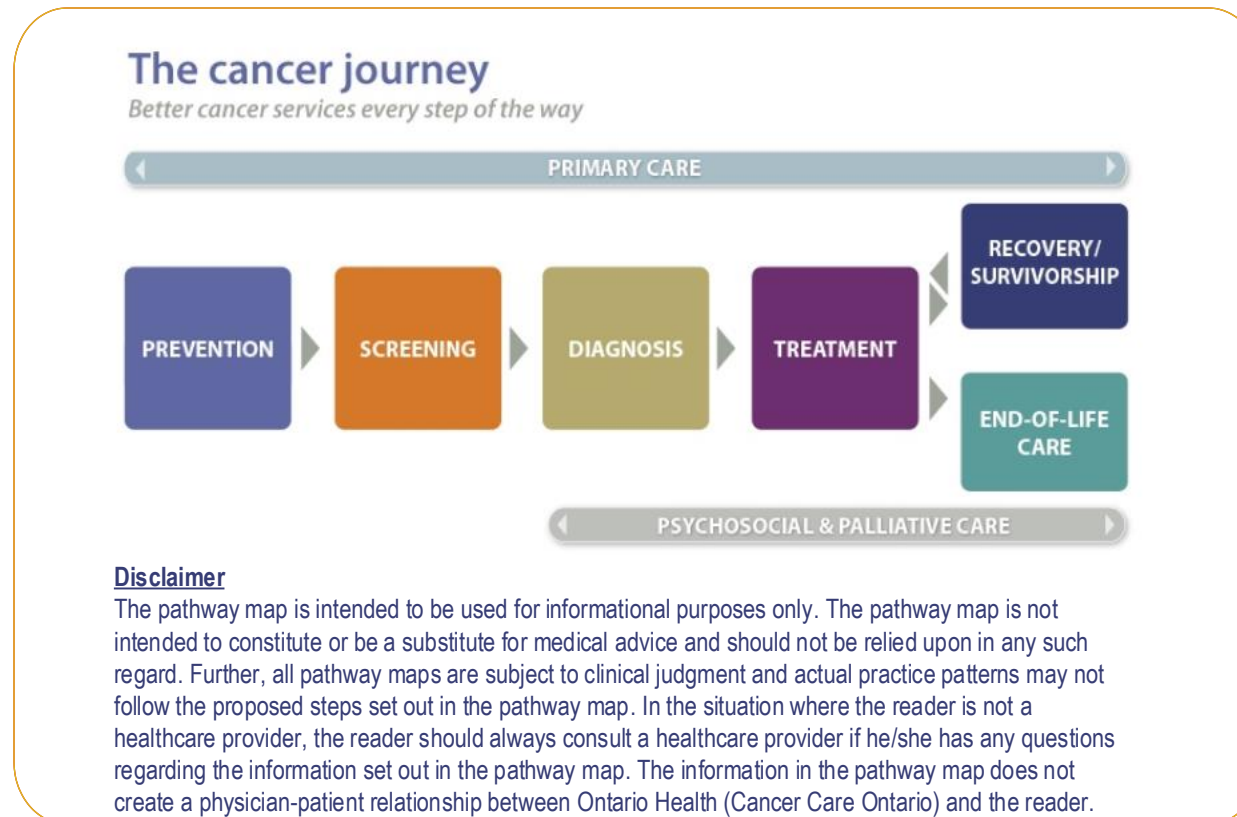


Rectal Cancer Treatment Pathway Map

Version 2020.01



Target Population

Patients with a confirmed rectal cancer diagnosis who have undergone the recommended diagnostic and staging procedures as outlined in the **Colorectal Cancer Diagnosis Pathway Map**.


Pathway Map Considerations

- All patients under consideration for an ostomy should be referred to an Enterostomal Therapy Nurse preoperatively. Patients should have access to an Enterostomal Therapy Nurse before and after ostomy surgery. Refer to: [Ostomy Care and Management, Clinical Best Practice Guideline, Registered Nurses Association of Ontario](#).
- 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](#).
- 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, nurse practitioners, and emergency physicians.
- 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 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 pathway map is only intended for primary adenocarcinoma. Familial cancers (Lynch/non-Lynch) and cancers in the settings of inflammatory bowel disease are handled differently.
- 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
- For more information on the systemic treatment QBP please refer to the: [Quality-Based Procedures Clinical Handbook for Systemic Treatment](#)










* **Note.** [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
	Endoscopy
	Palliative Care
	Pathology
	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/ Physician 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 Ontario Health (Cancer Care Ontario) and the reader.

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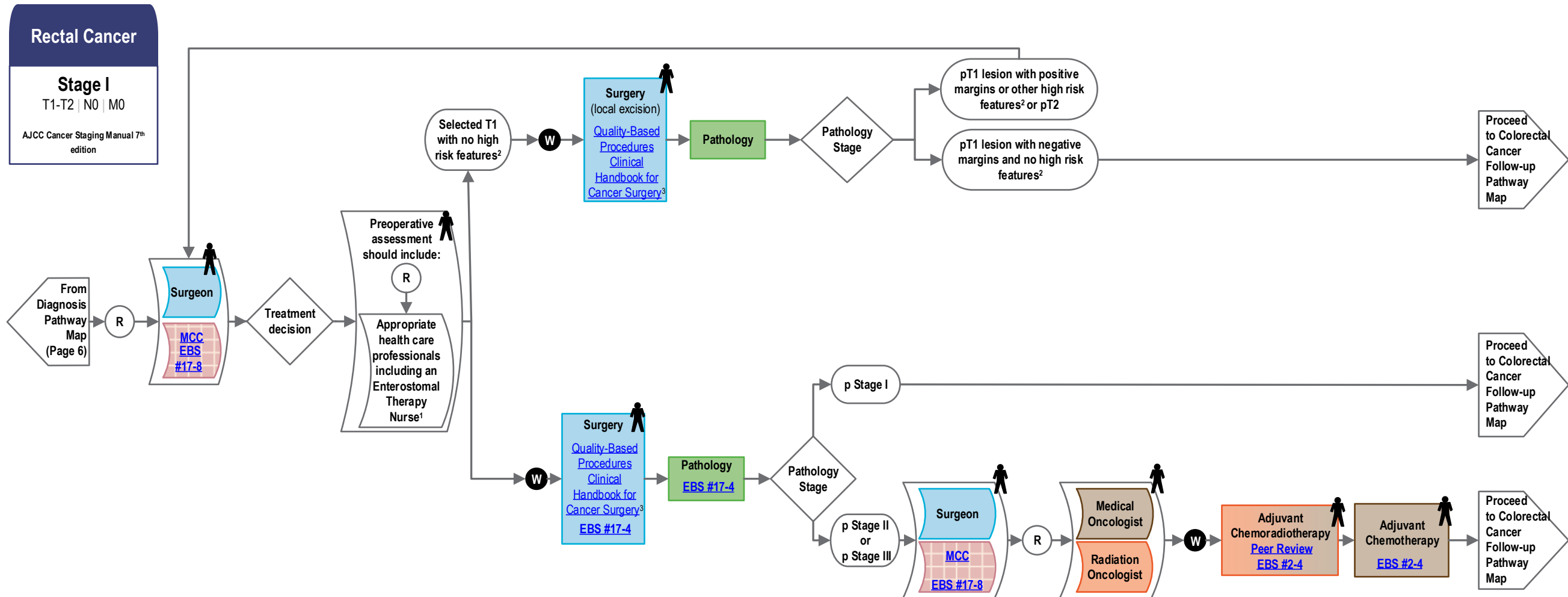
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This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in 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.

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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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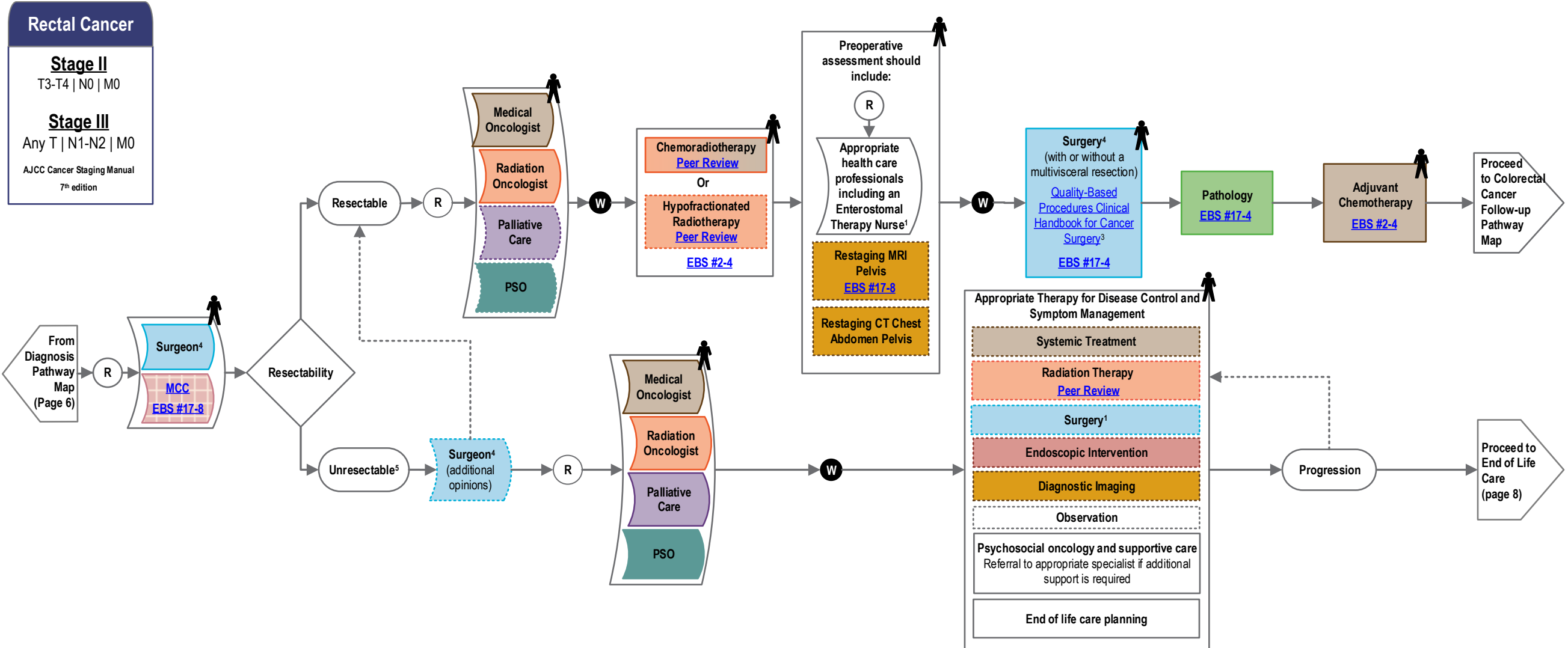
² High risk features include poorly differentiated histology, lymphovascular invasion (LVI), tumour budding and/or depth of invasion > 1000µm or submucosal layer (SM)³

³ For more information on Colorectal Cancer Surgery refer to pages 22-29 of the Quality-Based Procedures Clinical Handbook for Cancer Surgery

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⁴ For T4 lesions, patients may also be referred to urology, plastic surgery and/or vascular surgery.

⁵ Unresectable refers to a tumour that cannot be completely removed even with a multivisceral resection (i.e., pelvic sidewall invasion) and/or patient is unfit for major surgery. Goals of care should be discussed. Treatment plans should be based upon MCC recommendations

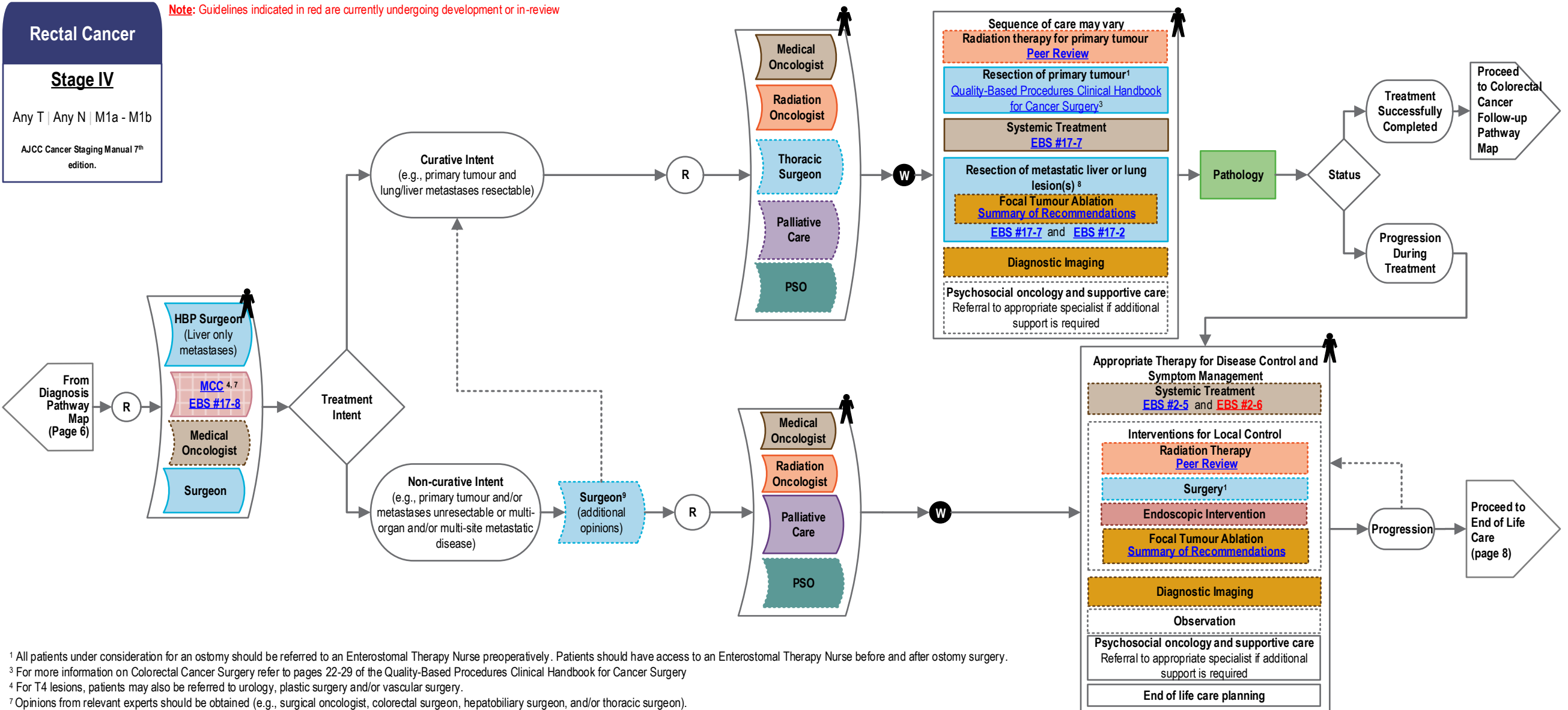
⁶ An additional opinion from a second surgical oncologist or colorectal surgeon to reassess resectability should be considered

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Note: Guidelines indicated in red are currently undergoing development or in-review

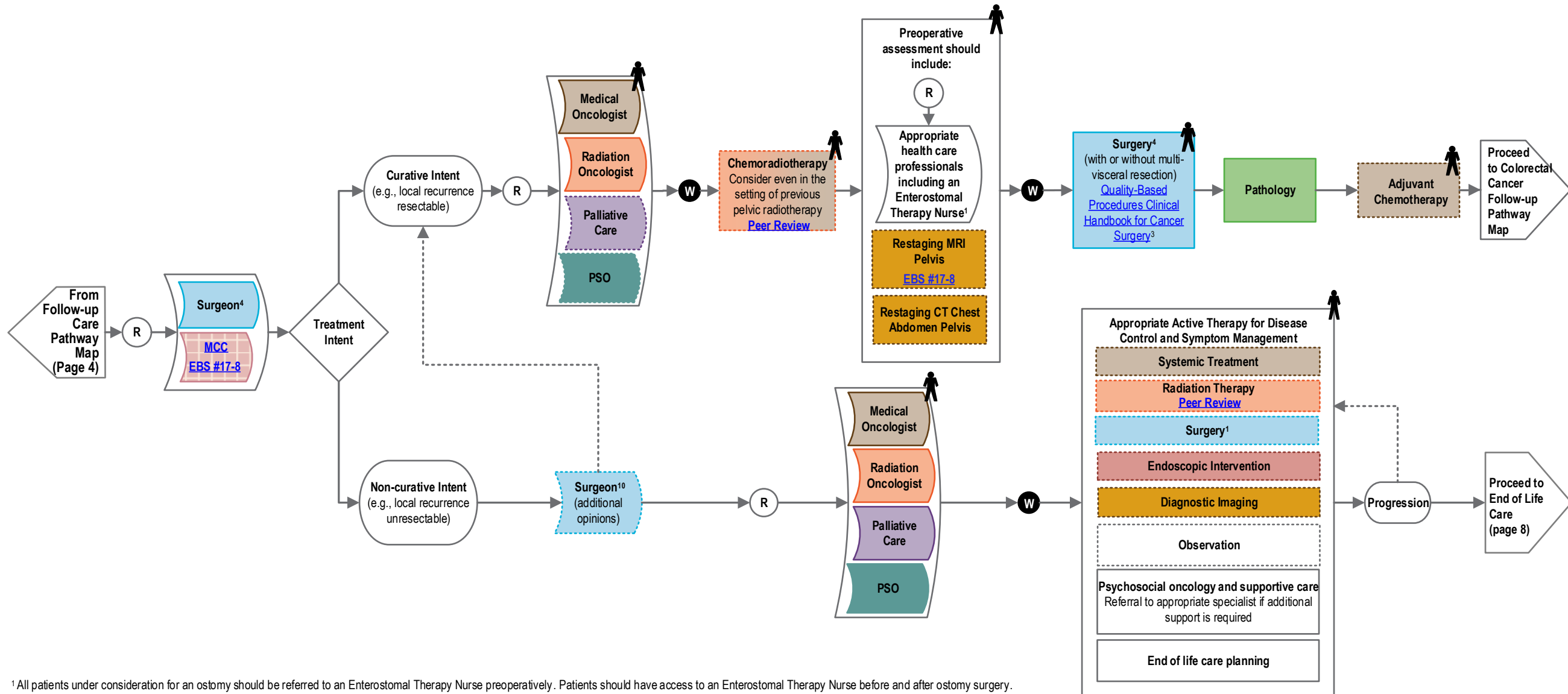


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⁴ For T4 lesions, patients may also be referred to urology, plastic surgery and/or vascular surgery.
⁷ Opinions from relevant experts should be obtained (e.g., surgical oncologist, colorectal surgeon, hepatobiliary surgeon, and/or thoracic surgeon).
⁸ Patients should be treated at a designated HPB Centre that has appropriate physical resources, staffing and a high volume of HPB surgeries. For more information on the optimum organization for the delivery of cancer-related hepatic, pancreatic, and biliary tract surgery refer to [EBS #17-2: Hepatic, Pancreatic, and Biliary Tract Surgical Oncology Standards](#)
⁹ An additional opinion from a second surgical oncologist, colorectal surgeon, hepatobiliary surgeon or thoracic surgeon to reassess treatment intent should be considered

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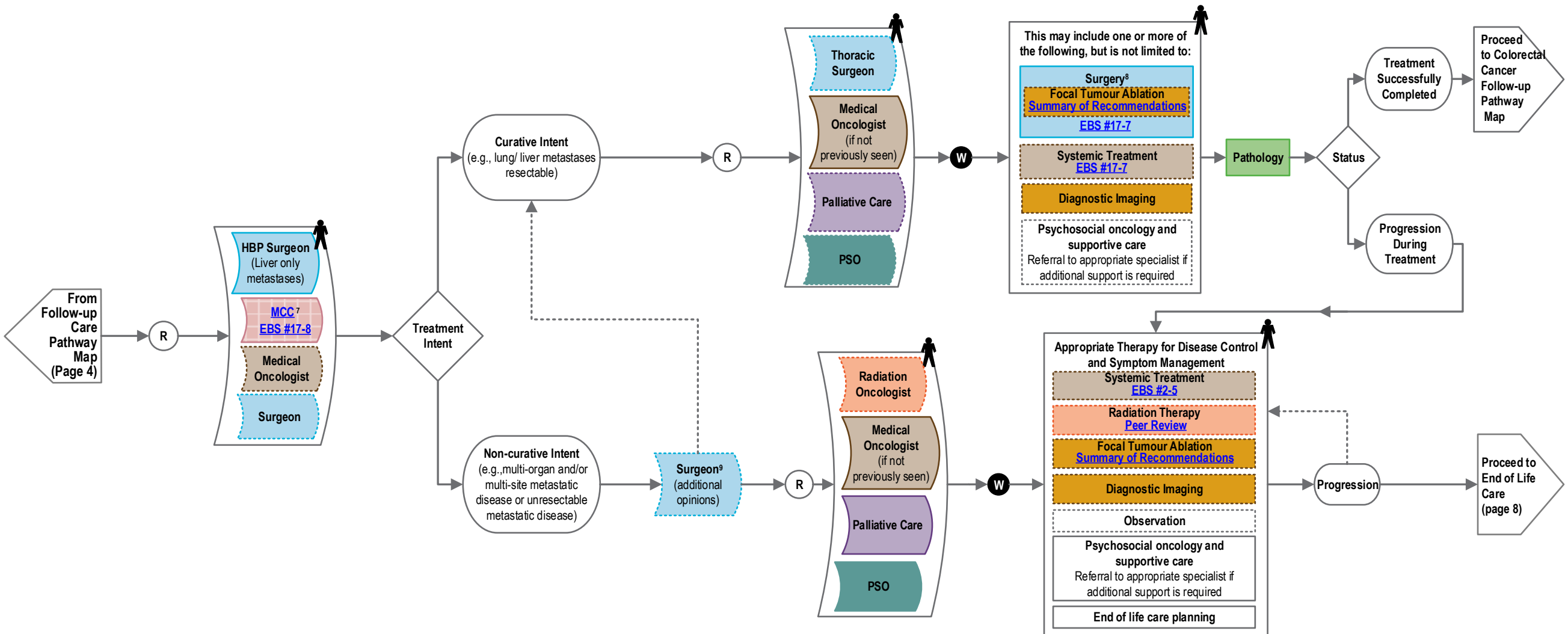
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Pathway Map Target Population:

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.

Triggers that suggest patients are nearing the last few months and weeks of life

- ECOG/Patient-ECOG/PRFS = 4
OR
- PPS ≤ 50
- Declining performance status/functional ability

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

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/complicated 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/caregivers 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

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