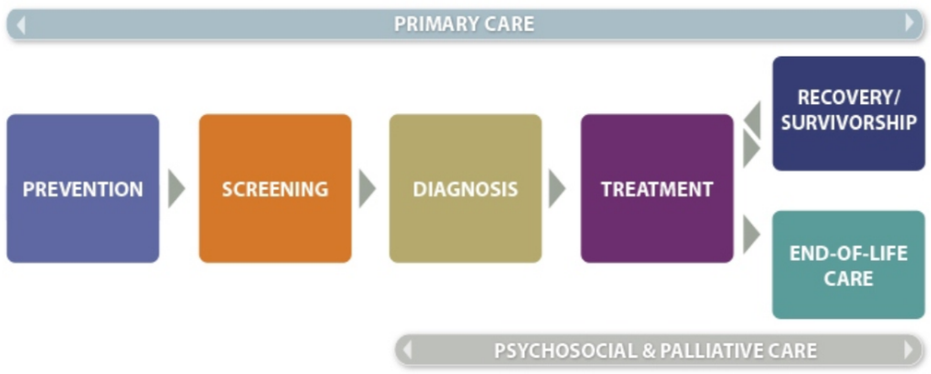
Cancer Care Ontario

Colon Cancer Treatment Pathway Map

Version 2018.03



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 Population

Patients with a confirmed colon 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 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.
- 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
- Diagnostic Assessment Program (DAP)
- 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 (or)
- Patient/Provider interaction
- R — Referral
- W — 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.

While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an "as-is" basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information's quality, accuracy, currency, completeness, or reliability.

CCO and the pathway map's content providers (including the physicians who contributed to the information in the pathway map) shall have no liability, whether direct, indirect, consequential, contingent, special, or incidental, related to or arising from the information in the pathway map or its use thereof, whether based on breach of contract or tort (including negligence), and even if advised of the possibility thereof. Anyone using the information in the pathway map does so at his or her own risk, and by using such information, agrees to indemnify CCO and its content providers from any and all liability, loss, damages, costs and expenses (including legal fees and expenses) arising from such person's use of the information in the pathway map.

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

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

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

Colon Cancer

Stage I
T1–T2 | N0 | M0

Stage II
T3-T4 | N0 | M0

Stage III
Any T | N1-N2 | M0

AJCC Cancer Staging Manual 7th edition

From Colorectal Cancer Screening & Diagnosis Pathway Maps

R

Surgeon[1]

MCC

Resectability

Resectable

Preoperative assessment should include:

R

Appropriate health care professionals including an Enterostomal Therapy Nurse[2]

W

Surgery (with or without multi-visceral resection)
Quality-Based Procedures Clinical Handbook for Cancer Surgery[6]
EBS #17-4

Pathology
EBS #17-4

Pathology Stage

p Stage I

p Stage II without high risk features[4]

p Stage II with high risk features[4]

R

Medical Oncologist

MCC

Adjuvant chemotherapy
EBS #2-29

Proceed to Colorectal Cancer Follow-up Pathway Map

p Stage III

R

Medical Oncologist

MCC

Adjuvant chemotherapy
EBS #2-29

Unresectable[3]

MCC

Surgeon[5] (additional opinions)

R

Medical Oncologist

Radiation Oncologist

Palliative Care

PSO

W

Appropriate Therapy for Disease Control and Symptom Management

- Chemotherapy
- Radiation Therapy
  Peer Review
- Surgery[2]
- Endoscopic Intervention
- Diagnostic Imaging
- Observation
- Psychosocial oncology and supportive care
  Referral to specialist if additional support is required
- End of life care planning

Progression

Proceed to End of Life Care Pathway Map (page 6)

[1] For T4 lesions, patients may also be referred to urology, plastic surgery, vascular surgery and/or hepatobiliary surgery.
[2] 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.
[3] 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.
[4] High-risk features include but are not limited to: inadequate samples of nodes, T4 lesions, perforation at the site of the tumour, or poorly differentiated histology in the absence of microsatellite instability.
[5] An additional opinion from a second surgical oncologist or colorectal surgeon to reassess resectability should be considered
[6] For more information on Colorectal Cancer Surgery refer to pages 22-29 of the Quality-Based Procedures Clinical Handbook for Cancer Surgery

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

Colon Cancer

Stage IV

Stage IVA

Any T | Any N | M1a

Stage IVB

Any T | Any N | M1b

AJCC Cancer Staging Manual 7th edition

From Diagnosis Pathway Map (Page 6)

R

HBP Surgeon (Liver metastases only)

MCC[7]

Medical Oncologist

Surgeon

EBS #17-8

Treatment Intent

Curative Intent
(e.g., primary tumour and lung/liver metastases resectable)

R

Medical Oncologist

Thoracic Surgeon

Palliative Care

PSO

W

Sequence of care may vary

Resection of primary tumour[2]
Quality-Based Procedures Clinical Handbook for Cancer Surgery[6]

Chemotherapy
EBS #17-7

Resection of metastatic liver or lung lesion(s)[8]
Focal Tumour Ablation
Summary of Recommendations
EBS #17-7 and EBS #17-2

Diagnostic Imaging

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

Pathology

Status

Treatment Successfully Completed

Proceed to Colorectal Cancer Follow-up Pathway Map

Progression During Treatment

Non-curative Intent
(e.g., primary tumour and/or metastases unresectable or multi-organ and/or multi-site metastatic disease)

Surgeon[9] (additional opinions)

R

Medical Oncologist

Radiation Oncologist

Palliative Care

PSO

W

Appropriate Therapy for Disease Control and Symptom Management

Chemotherapy
EBS #2-5 and EBS #2-6

Interventions for Local Control

Radiation Therapy
Peer Review

Surgery[2]

Endoscopic Intervention

Focal Tumour Ablation
Summary of Recommendations

Diagnostic Imaging

Observation

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

End of life care planning

Progression

Proceed to End of Life Care Pathway Map (page 8)

[2] 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.

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

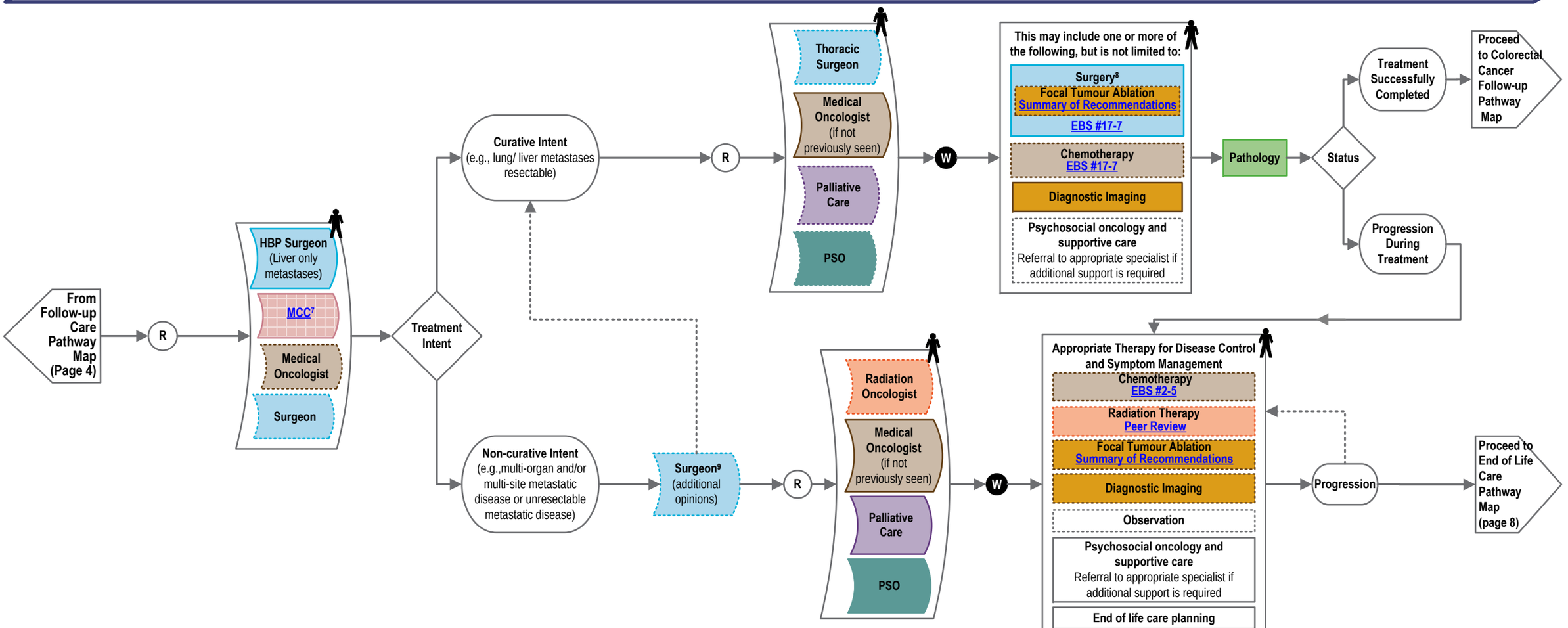
[7] Opinions from relevant experts should be obtained (e.g., surgical oncologist, colorectal surgeon, hepatobiliary surgeon, and/or thoracic surgeon). For T4 lesions, patients may also be referred to urology, plastic surgery and/or vascular surgery.

[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

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



[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

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 (refer to Collaborative Care Plan)

☐ **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

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/