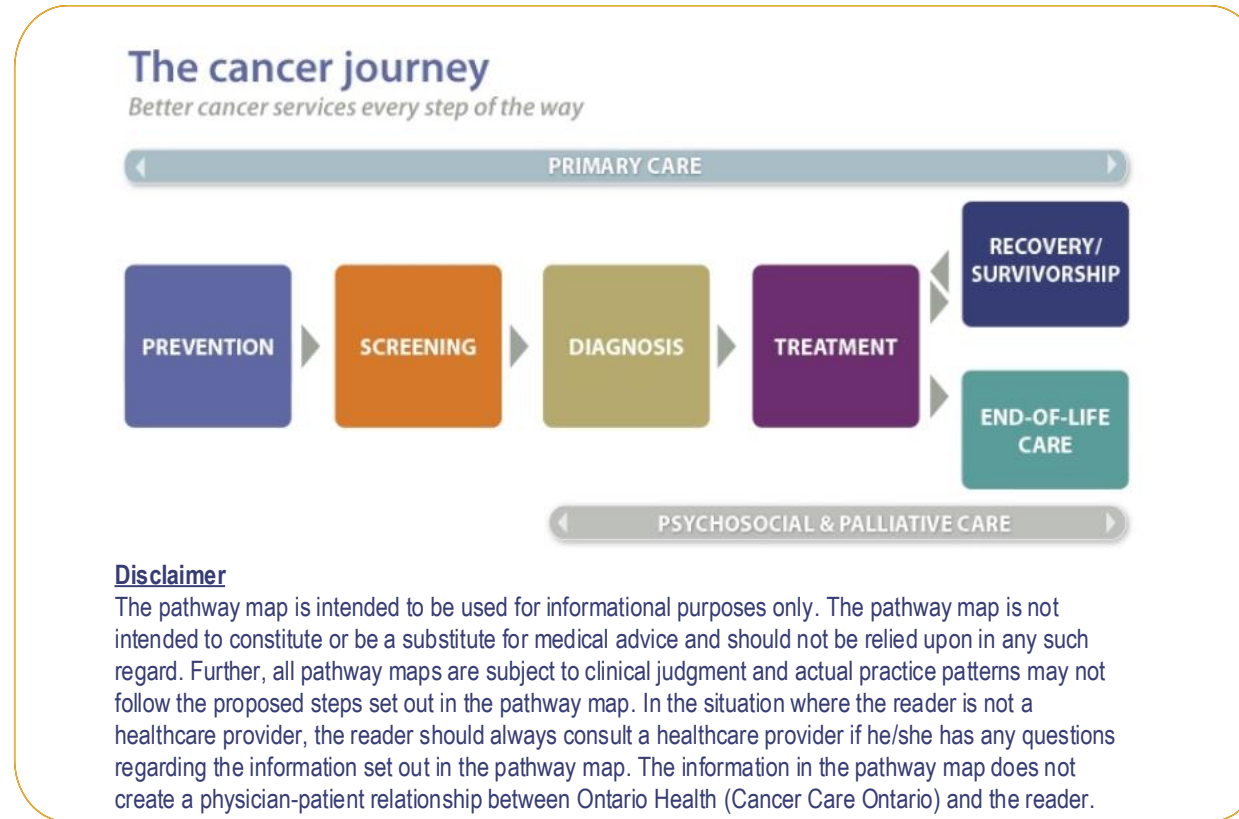


# Endometrioid Epithelial Ovarian Cancer Treatment and Follow-up Pathway Map

Version 2020.01



## Target Population

- Women presenting with epithelial ovarian cancer











## Pathway Map Considerations

- For more information about the optimal organization of gynecologic oncology services in Ontario refer to [EBS #4-11](#)
- The staging system used throughout the Ovarian Cancer Treatment Pathway is the 2014 FIGO staging system.
- 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 'healthcare provider', used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, gynecologists, midwives 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 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\\*](#)
- 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










\* **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.

## Pathway Map Legend



### Colour Guide

	Primary Care
	Palliative Care
	Pathology
	Gynecologic Oncology
	Radiation Oncology
	Medical Oncology
	Radiology
	Gynecology
	Genetics
	Multidisciplinary Cancer Conference (MCC)

### 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.

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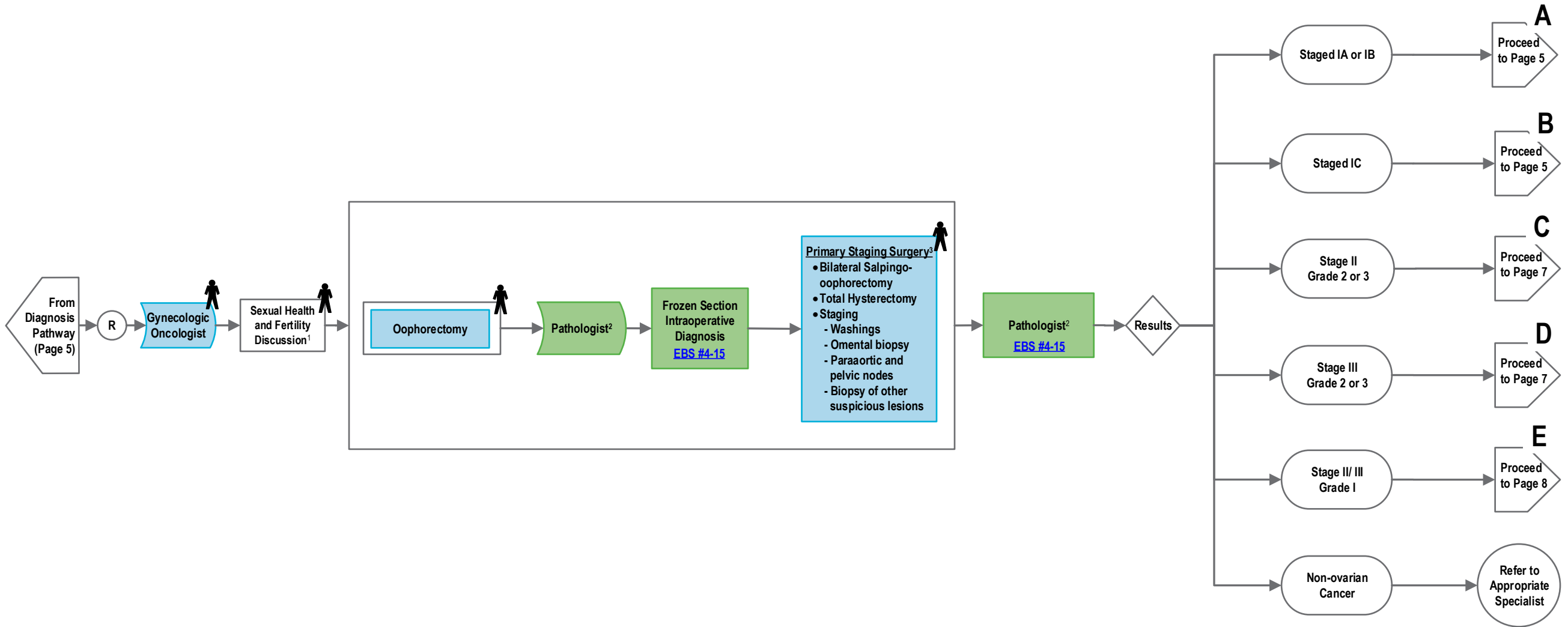
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Screen for psychosocial needs, and assessment and management of symptoms. [Click here for more information about symptom assessment and management tools](#)

Consider the introduction of palliative care, early and across the cancer journey [Click here for more information about palliative care](#)



<sup>1</sup> Discussion to be individualized for each patient; however, may include the following: age, fertility preservation, hormone replacement therapy, referral for infertility consultation, etc

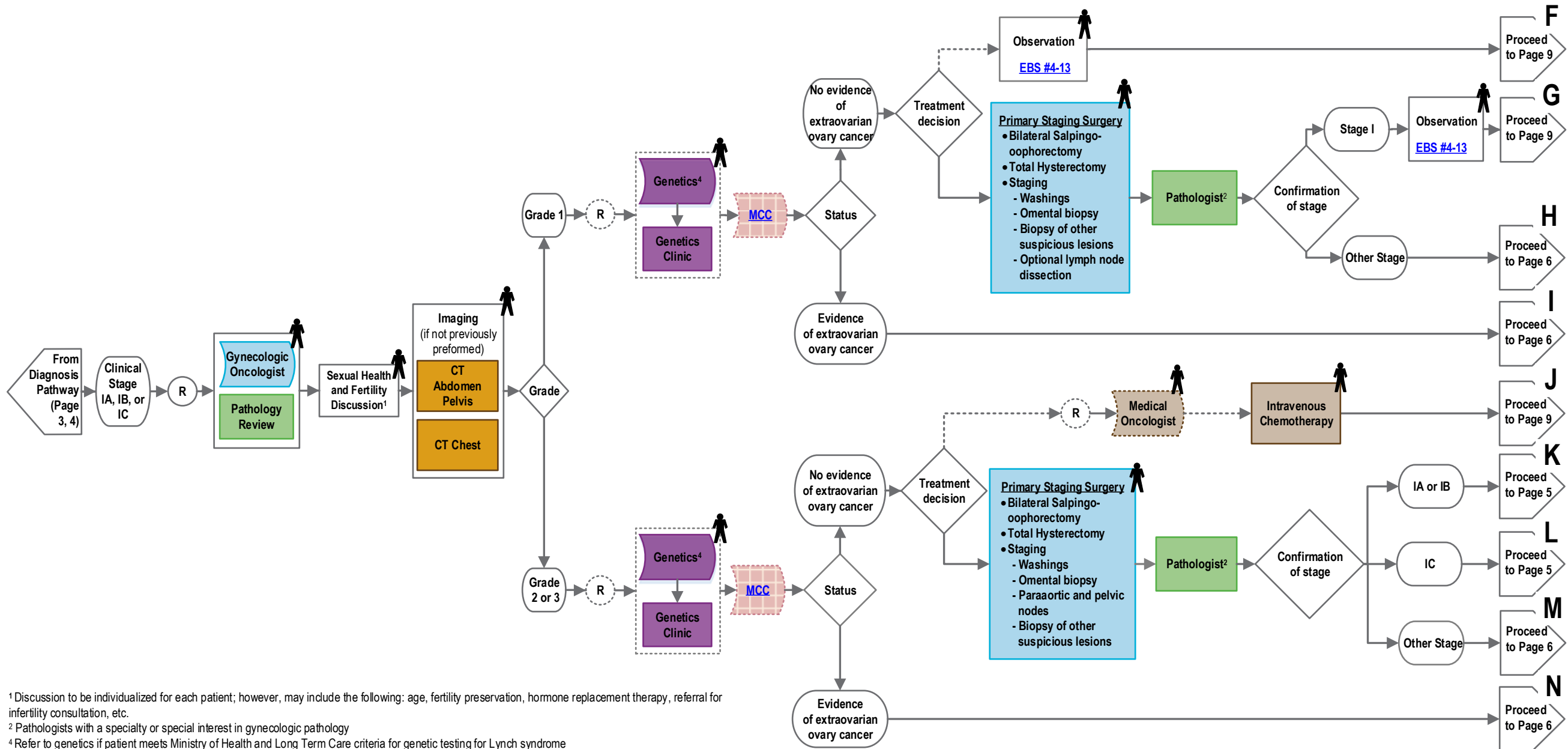
<sup>2</sup> Pathologists with a specialty or special interest in gynecologic pathology.

<sup>3</sup> If appropriate, the option of fertility sparing surgery should be discussed with the patient.

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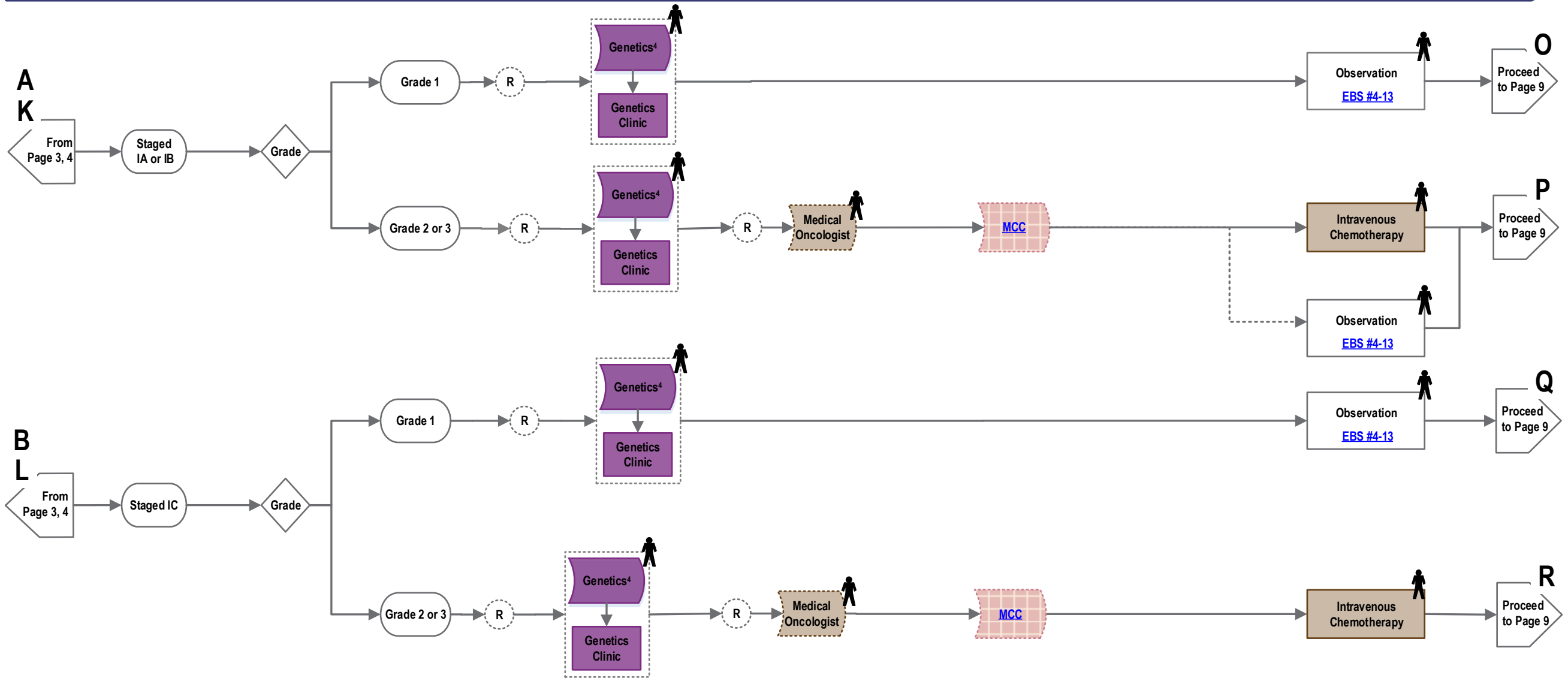
<sup>2</sup> Pathologists with a specialty or special interest in gynecologic pathology

<sup>4</sup> Refer to genetics if patient meets Ministry of Health and Long Term Care criteria for genetic testing for Lynch syndrome

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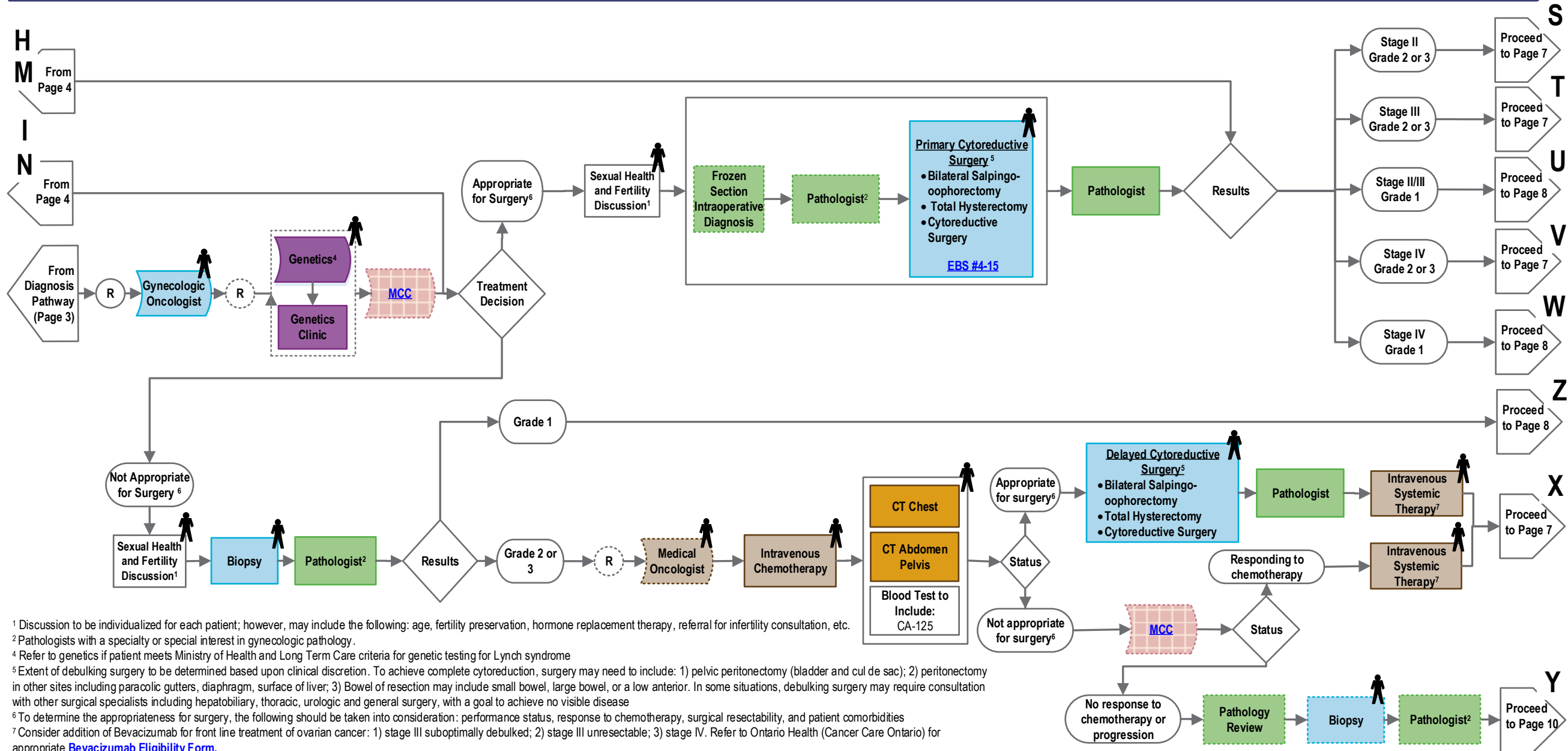


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<sup>5</sup> Extent of debulking surgery to be determined based upon clinical discretion. To achieve complete cytoreduction, surgery may need to include: 1) pelvic peritonectomy (bladder and cul de sac); 2) peritonectomy in other sites including paracolic gutters, diaphragm, surface of liver; 3) Bowel of resection may include small bowel, large bowel, or a low anterior. In some situations, debulking surgery may require consultation with other surgical specialists including hepatobiliary, thoracic, urologic and general surgery, with a goal to achieve no visible disease

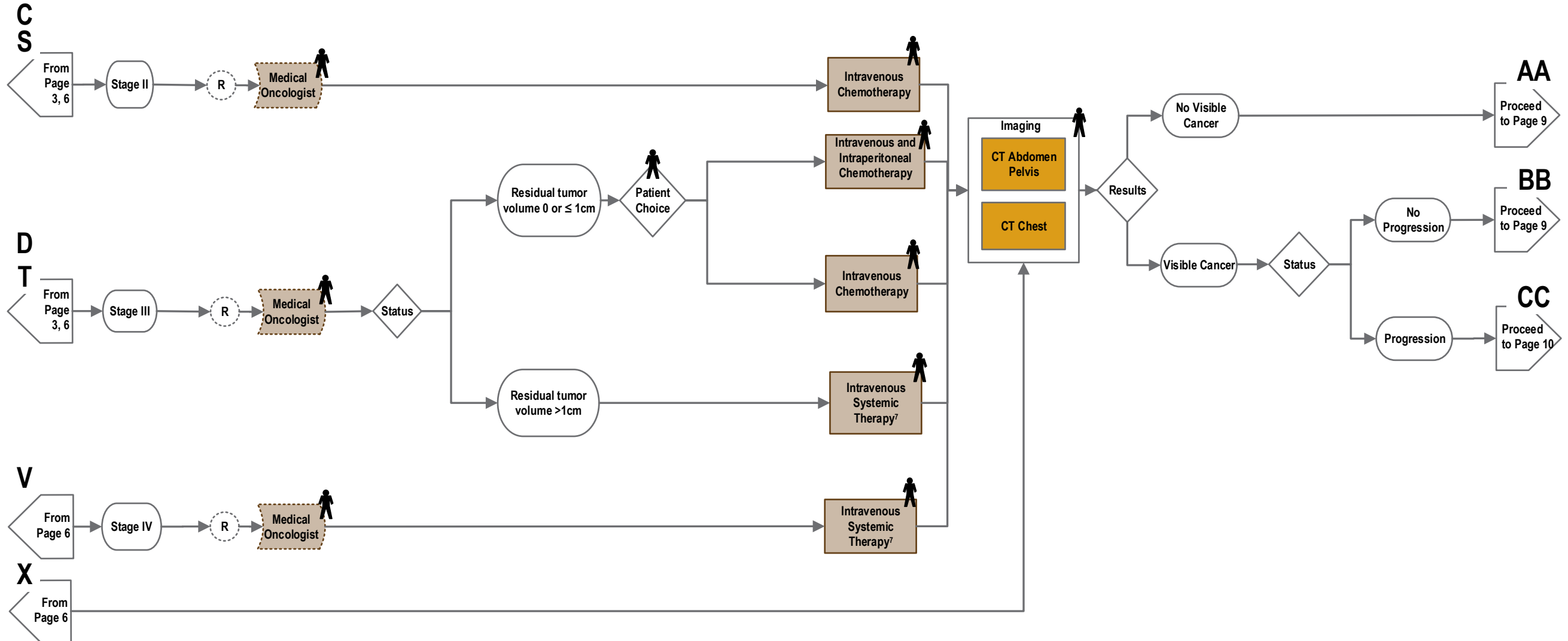
<sup>6</sup> To determine the appropriateness for surgery, the following should be taken into consideration: performance status, response to chemotherapy, surgical resectability, and patient comorbidities

<sup>7</sup> Consider addition of Bevacizumab for front line treatment of ovarian cancer: 1) stage III suboptimally debulked; 2) stage III unresectable; 3) stage IV. Refer to Ontario Health (Cancer Care Ontario) for appropriate [Bevacizumab Eligibility Form](#).

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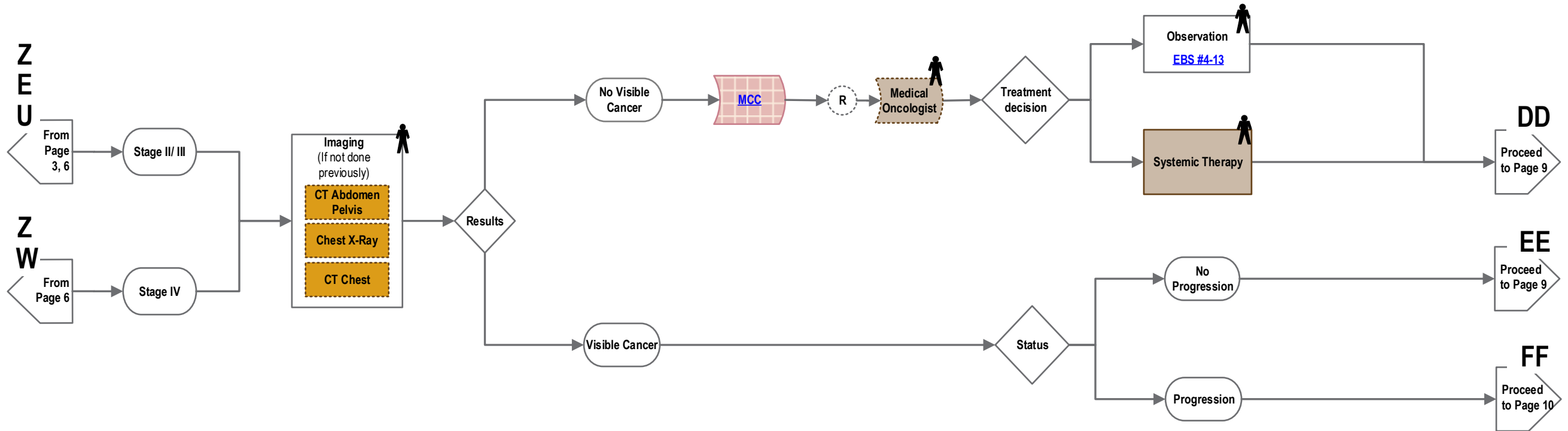


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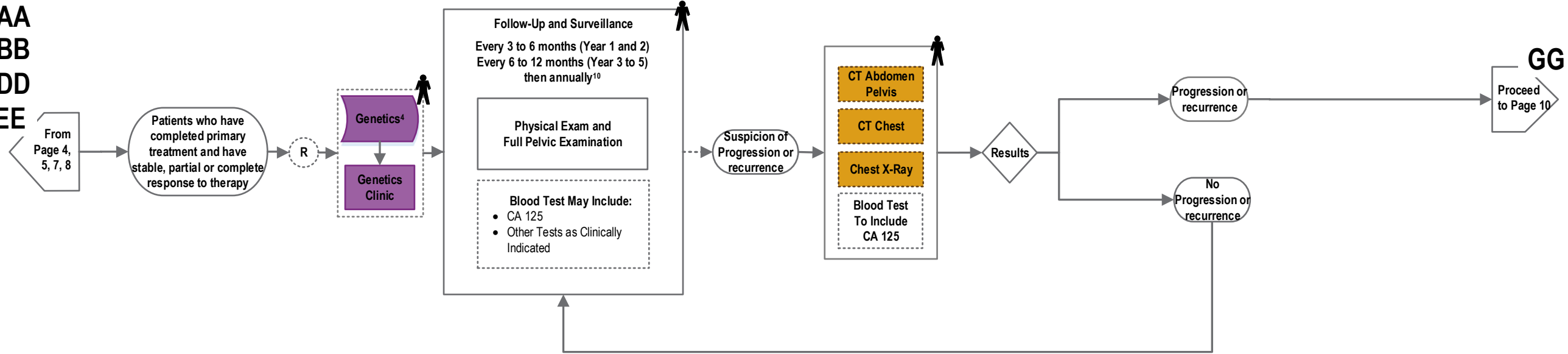


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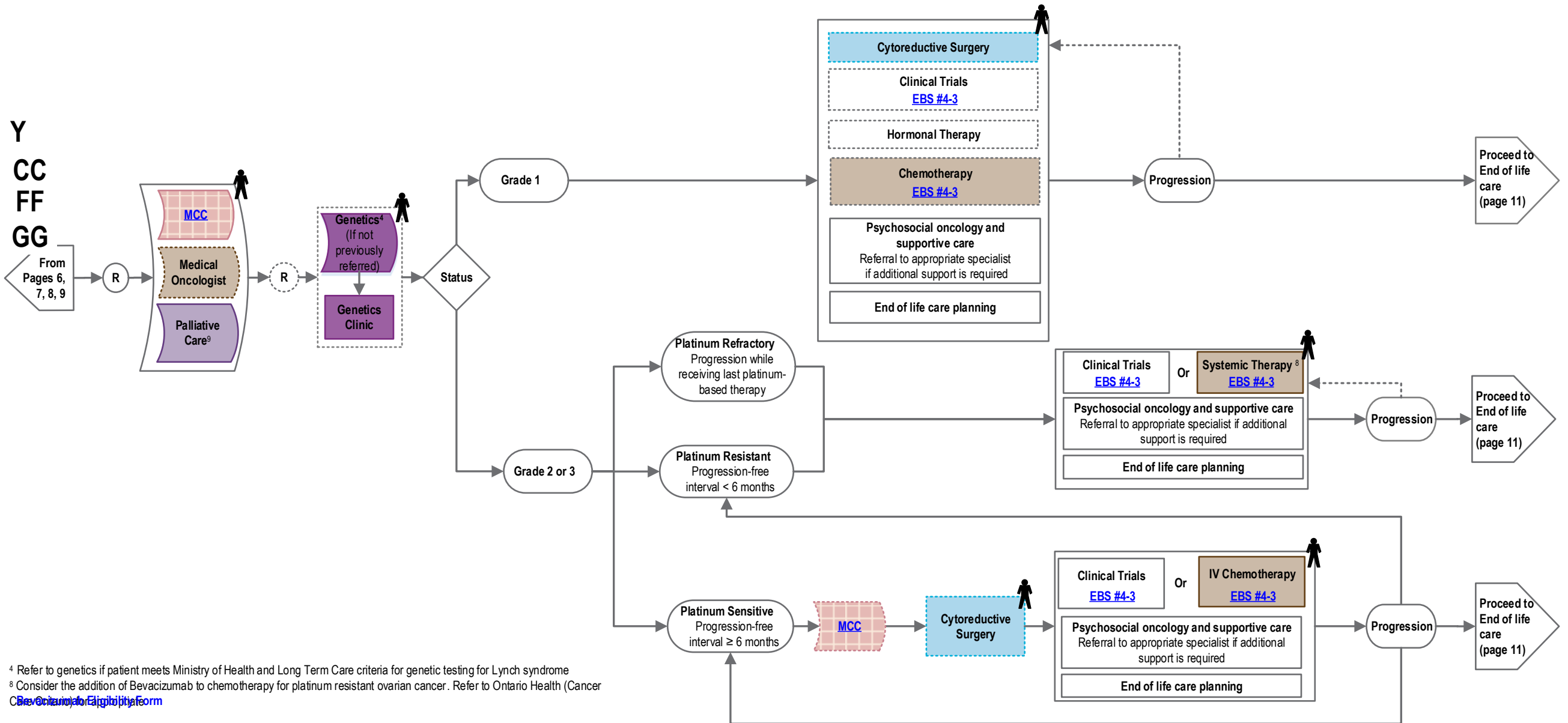
<sup>4</sup> Refer to genetics if patient meets Ministry of Health and Long Term Care criteria for genetic testing for Lynch syndrome

<sup>10</sup> Annual follow-up by gynecologist, family doctor or gynecologic oncologist.

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<sup>4</sup> Refer to genetics if patient meets Ministry of Health and Long Term Care criteria for genetic testing for Lynch syndrome  
<sup>8</sup> Consider the addition of Bevacizumab to chemotherapy for platinum resistant ovarian cancer. Refer to Ontario Health (Cancer Care Ontario) Eligibility Form

<sup>9</sup> For more information about early palliative care for advanced cancer refer to Zimmermann et al., (2014) Early palliative care for patients with advanced cancer: a cluster-randomized controlled trial. Lancet, 383(9930), 1721-30.

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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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