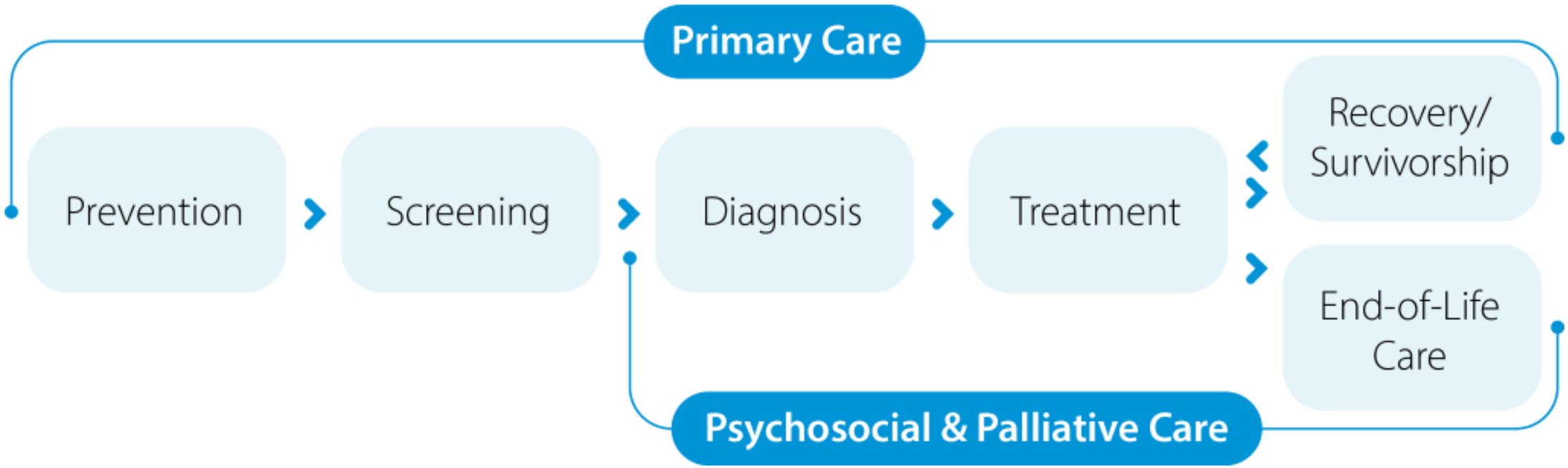
Esophageal Cancer Treatment Pathway Map

Version 2023.01



Ontario Health
Cancer Care Ontario

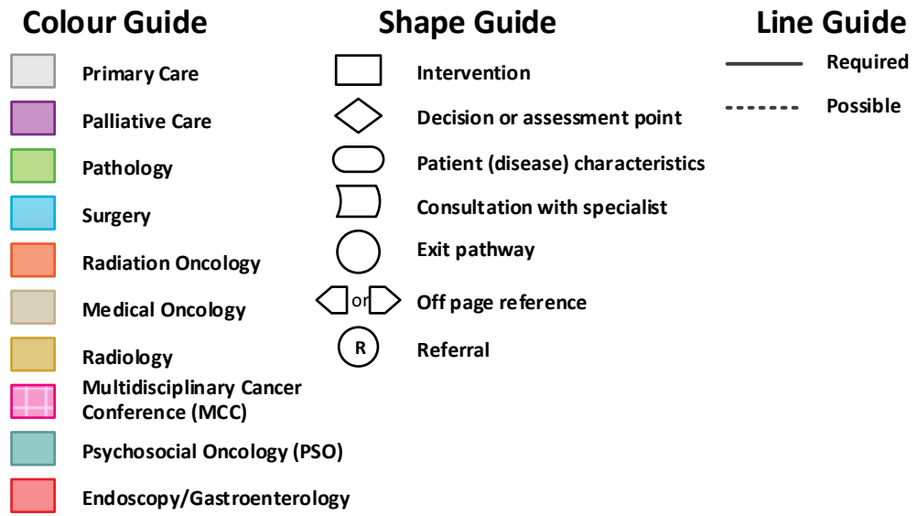
Target Population

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

Pathway Map Considerations

- Counseling and treatment for smoking cessation should be initiated early on in the pathway and continued by care provider throughout the pathway as necessary **Smoking Cessation Information for Healthcare Providers**.
- 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.
- Sexual health should be considered throughout the care continuum. Healthcare providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See **Psychosocial Oncology Guidelines Resources**.
- Before initiating gonadotoxic therapy (e.g. surgery, systemic, radiation), healthcare providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See **Ontario Fertility Program**.
- 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 Legend



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.

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.

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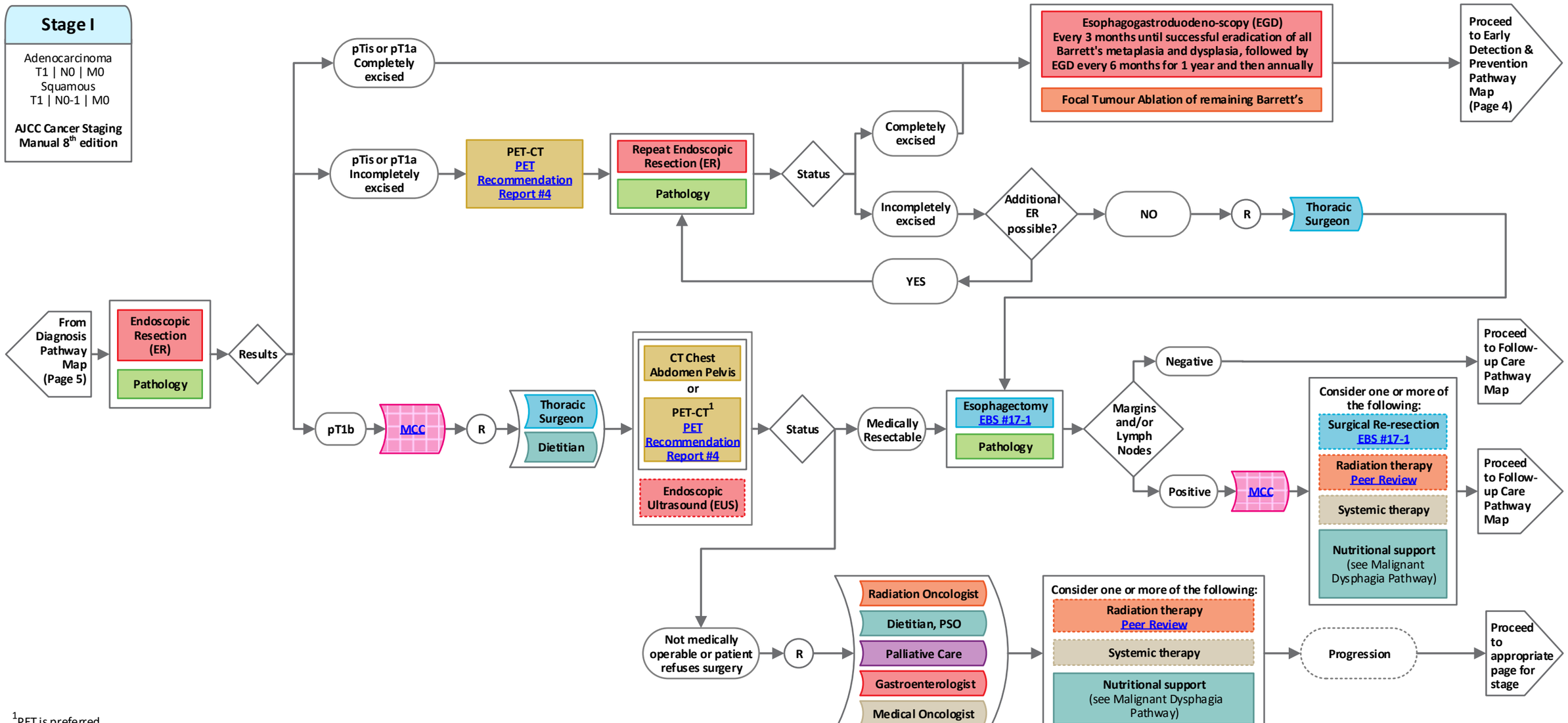
This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant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

* **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.

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



[1]PET is preferred.

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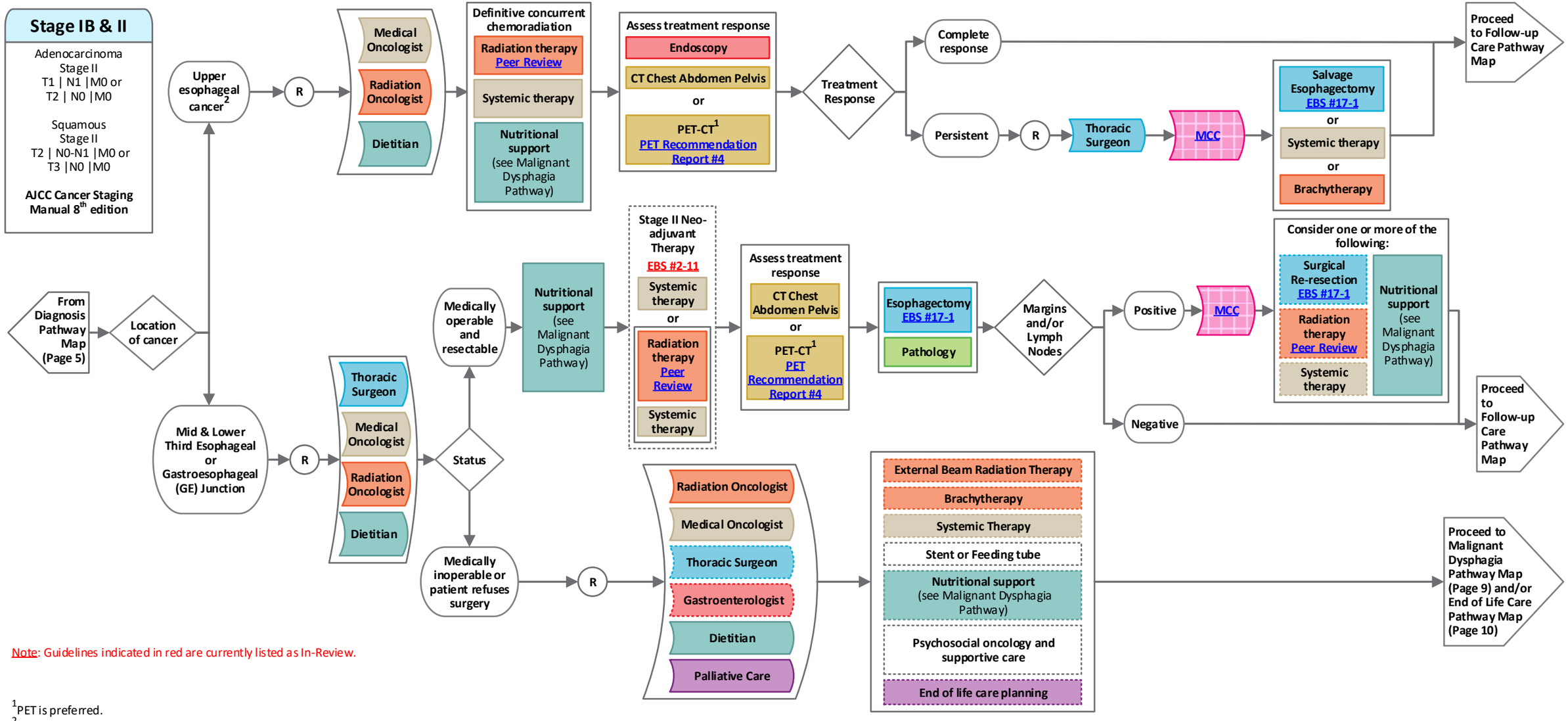

Note: Guidelines indicated in red are currently listed as In-Review.

[1] PET is preferred.

[2] Upper Thoracic Esophagus: 20 to 25cm from upper central incisor teeth on esophagogastroduodenoscopy (EGD).

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Stage III & IVA

Squamous	Adenocarcinoma
Stage III T3 | N1 | M0 or T1-3 | N2 | M0	**Stage III** T2 | N1 | M0 or T3-T4a | N0-N1 | M0
Stage IVA T4 | N0-N3 | M0 or Any T | N3 | M0	**Stage IVA** T1-4a | N2 | M0 or T4b | N0-2 | M0 or Any T | N3 | M0

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From Diagnosis Pathway Map (Page 5)

R

Medical Oncologist
Radiation Oncologist
Thoracic Surgeon
Dietitian
MCC

Status

Potentially resectable

Concurrent Neoadjuvant Chemoradiation
EBS #2-11
Radiation therapy
Peer Review
Systemic therapy
Nutritional support (see Malignant Dysphagia Pathway)

Reassessment of treatment response
PET-CT[1] (approximately 4 weeks post treatment)
PET Recommendation Report #4

Treatment response
- Progression → Proceed to Page 7
- Complete or partial response, patient stable → Esophagectomy EBS #17-1 → Proceed to Page 6

Unresectable/ patient declines surgery and good performance status

Concurrent Definitive Chemoradiation
EBS #2-12
Radiation therapy
Peer Review
Systemic therapy
Nutritional support (see Malignant Dysphagia Pathway)

Reassessment of treatment response
CT Chest Abdomen Pelvis
or
PET-CT[1] (approximately 4 weeks post treatment)
PET Recommendation Report #4

Treatment response
- Complete response → Proceed to Follow-up Care Pathway Map
- Persistent or progression → Proceed to Page 7

Unresectable and poor performance status

R

Palliative Care
PSO

- Palliative systemic therapy
- Palliative External Beam Radiation Therapy
- Palliative Brachytherapy
- Psychosocial oncology and supportive care
- End of life care planning
- Nutritional support (see Malignant Dysphagia Pathway)

→ Proceed to End of Life Care Pathway Map (Page 10)

Note: Guidelines indicated in red are currently listed as In-Review or Education and Information.

[1] PET is preferred.

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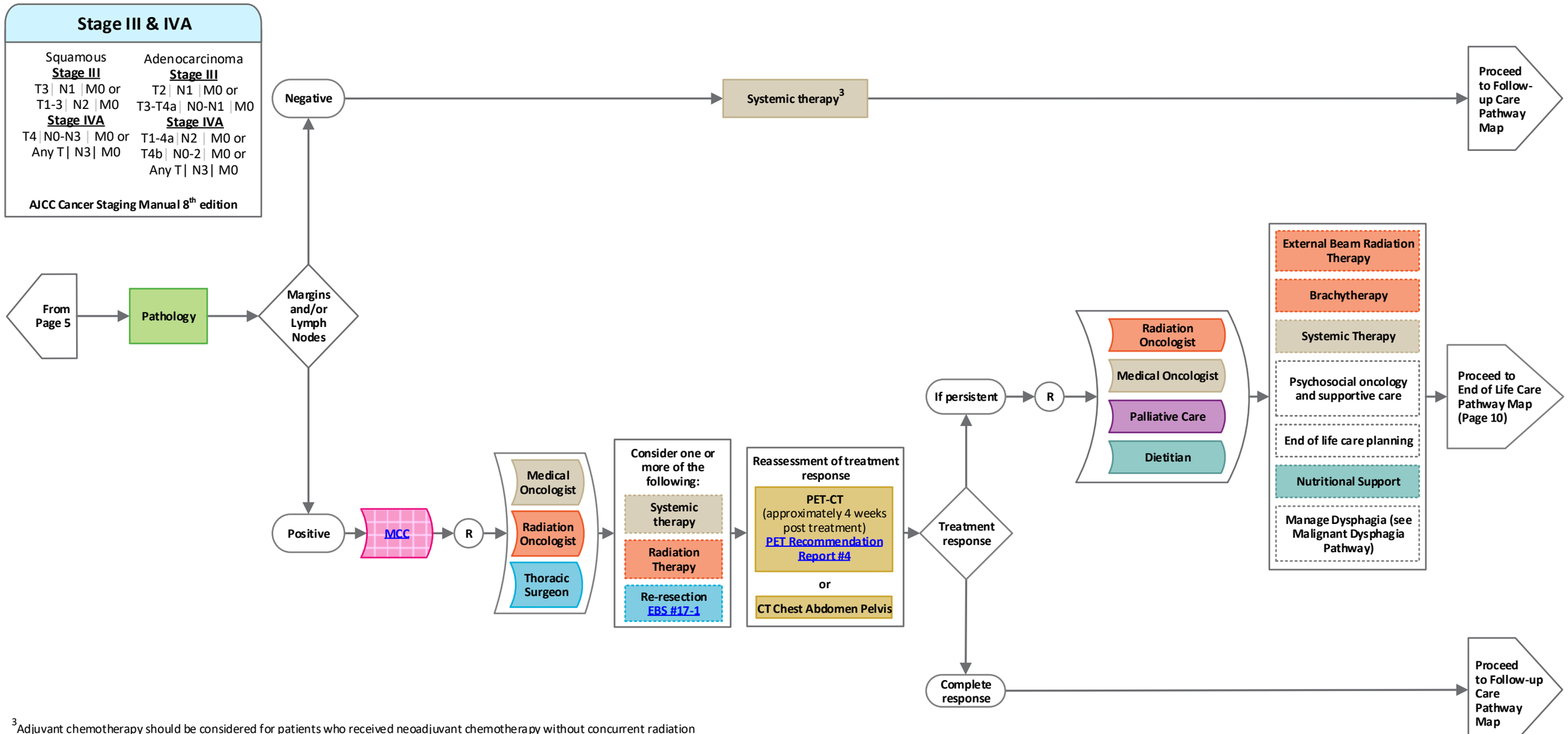

[3] Adjuvant chemotherapy should be considered for patients who received neoadjuvant chemotherapy without concurrent radiation

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Stage IVB

Any T | Any N | M1

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From Page 5 or Diagnosis Pathway Map (Page 5)

MCC

R

- Radiation Oncologist
- Medical Oncologist
- Palliative Care
- Dietitian

- External Beam Radiation Therapy
- Brachytherapy
- Systemic Therapy
- Psychosocial oncology and supportive care
- End of life care planning
- Nutritional Support
- Manage Dysphagia (see Malignant Dysphagia Pathway)

Proceed to Malignant Dysphagia Pathway (Page 9) and/or End of Life Care (Page 10)

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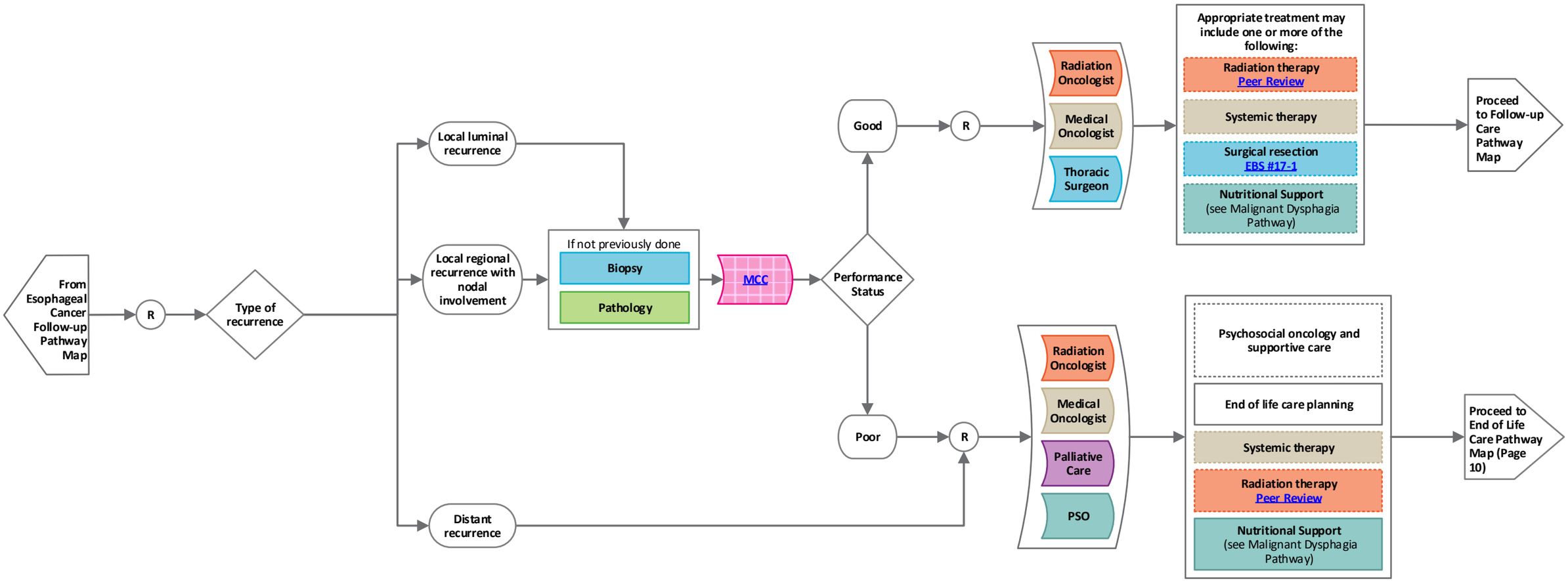

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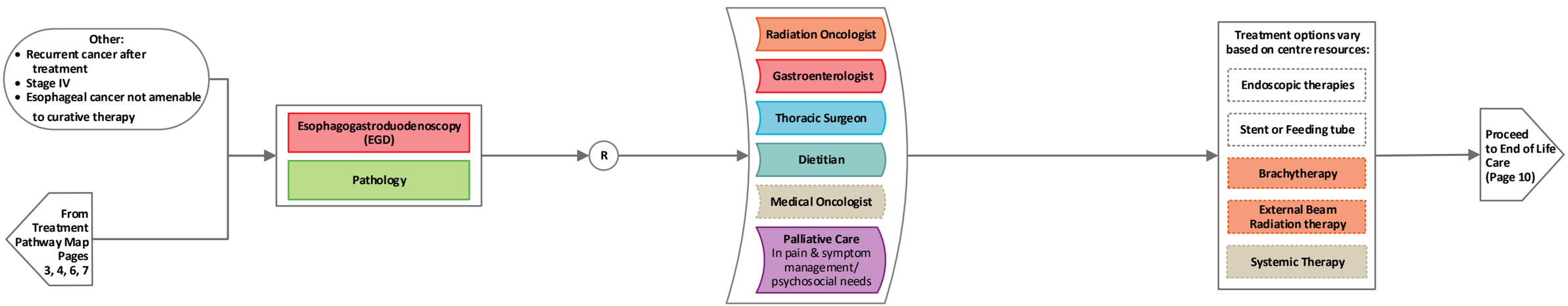

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Pathway Map Target Population:

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/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

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Patient Death

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