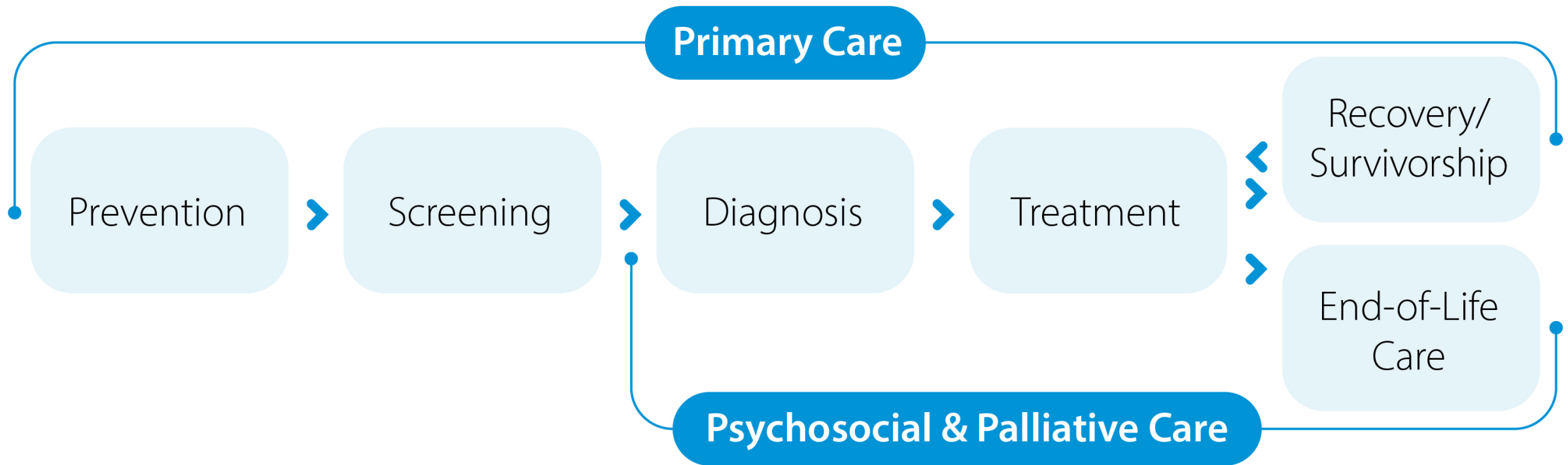


Small Cell Lung Cancer Treatment Pathway Map

Version 2023.04



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

















Target Population

Patients with a confirmed 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

- 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, [Health811](#) 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-Centred 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 Legend

Colour Guide	Shape Guide	Line Guide
 Primary Care	 Intervention	 Required
 Palliative Care	 Decision or assessment point	 Possible
 Pathology	 Patient (disease) characteristics	
 Surgery	 Consultation with specialist	
 Radiation Oncology	 Exit pathway	
 Medical Oncology	 Off page reference	
 Radiology	 Referral	
 Multidisciplinary Cancer Conference (MCC)		
 Psychosocial Oncology (PSO)		

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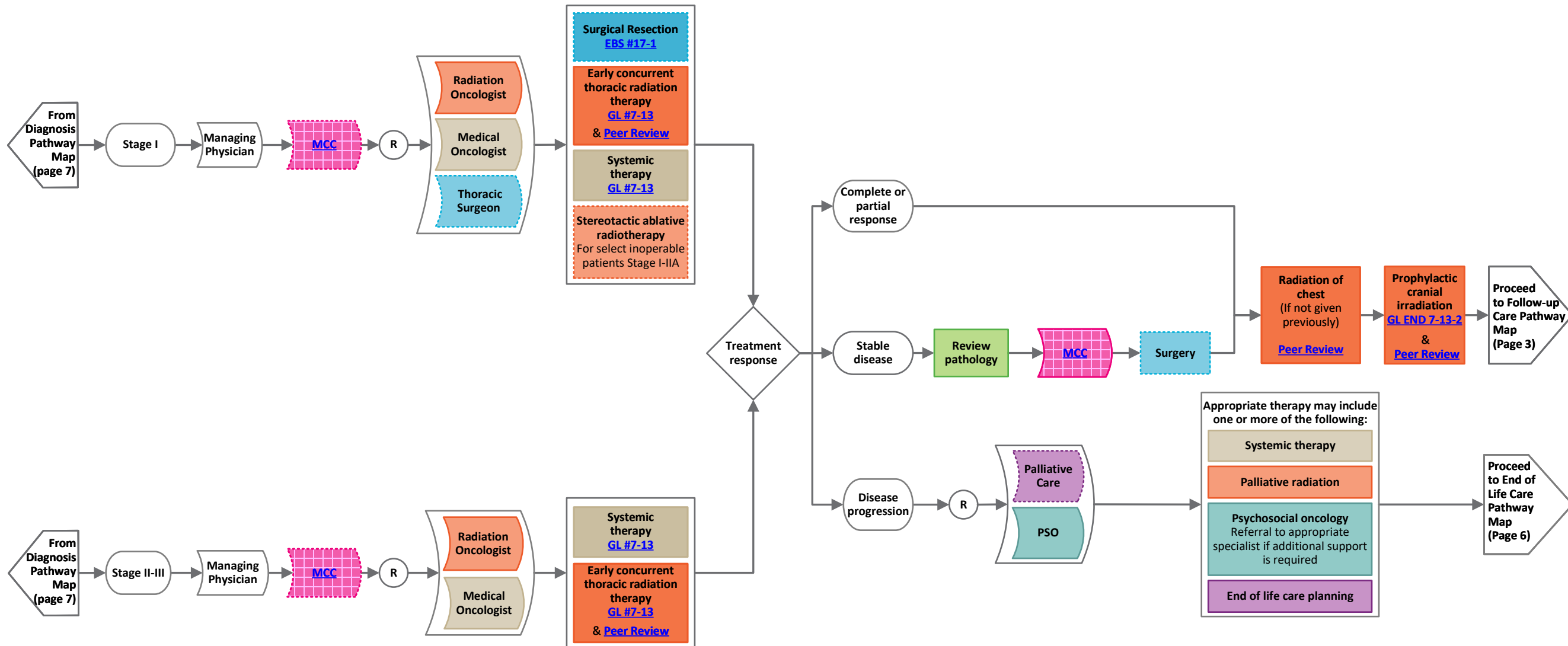
This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant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

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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](#)

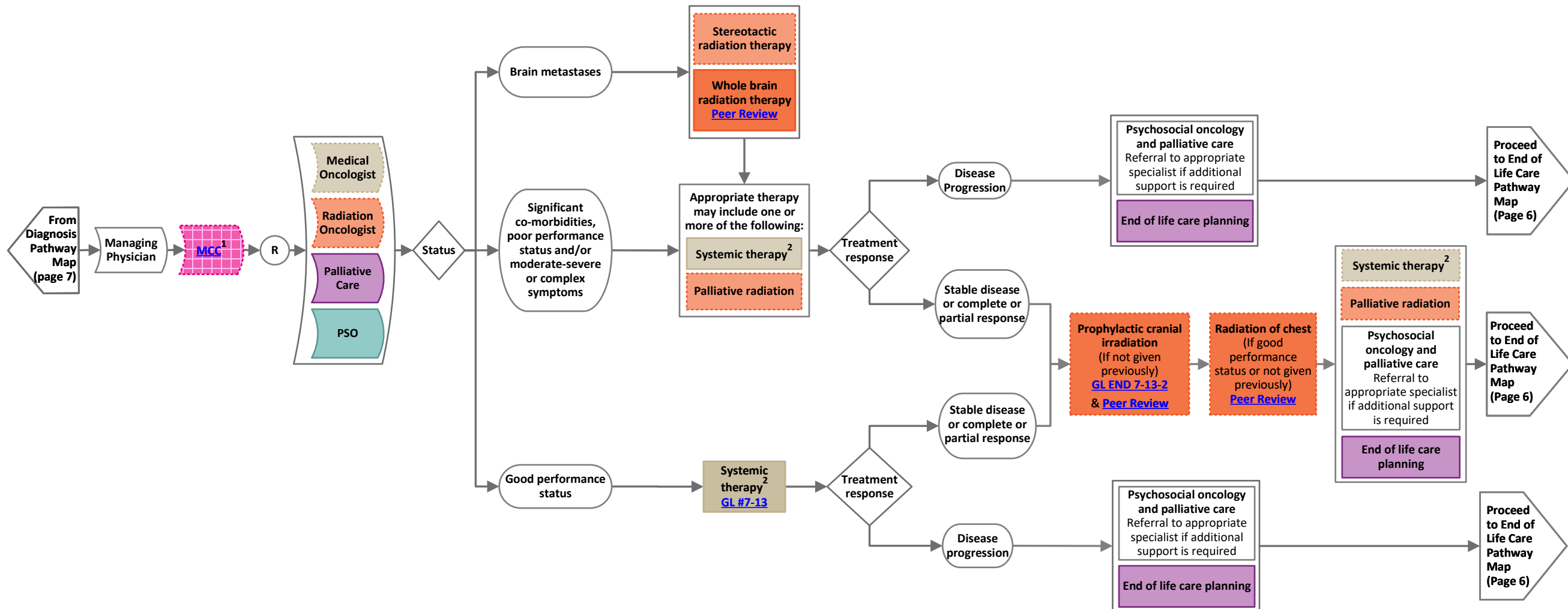
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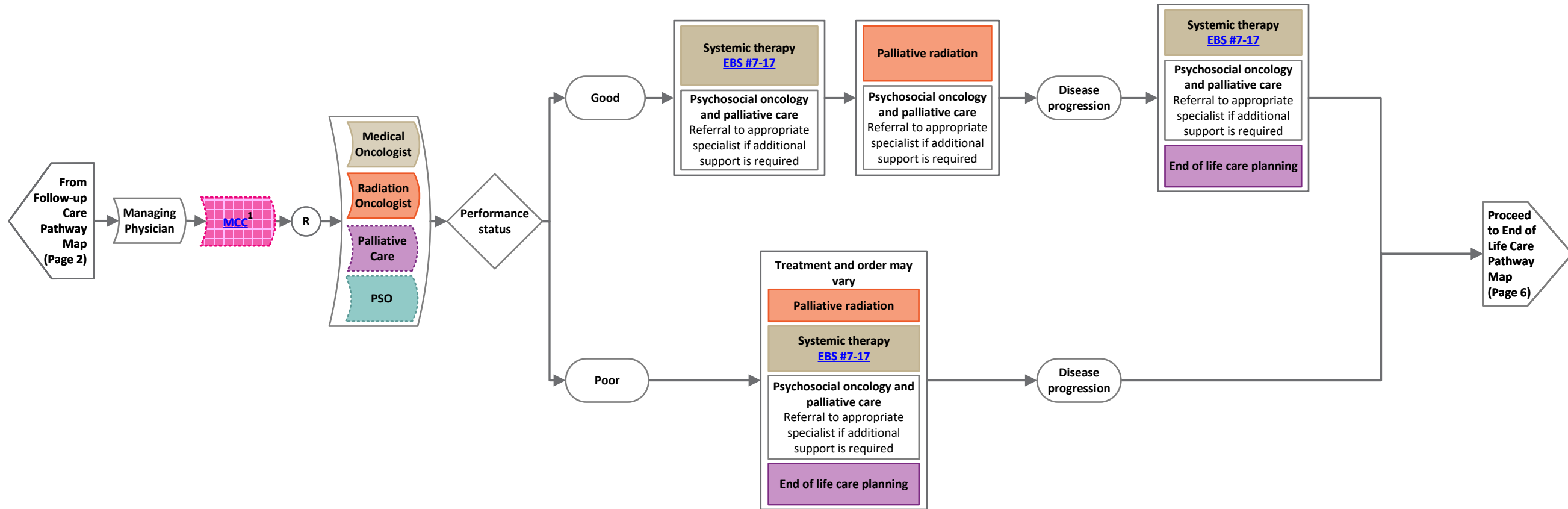
¹Key factors to consider in treatment decision include performance status, weight loss, disease symptoms, co-morbidities, sites of metastatic disease, molecular testing, patient wishes and understanding, and emotional status.

²Chemotherapy and immunotherapy are recommended for disease progression only and not for maintenance in SCLC.

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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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