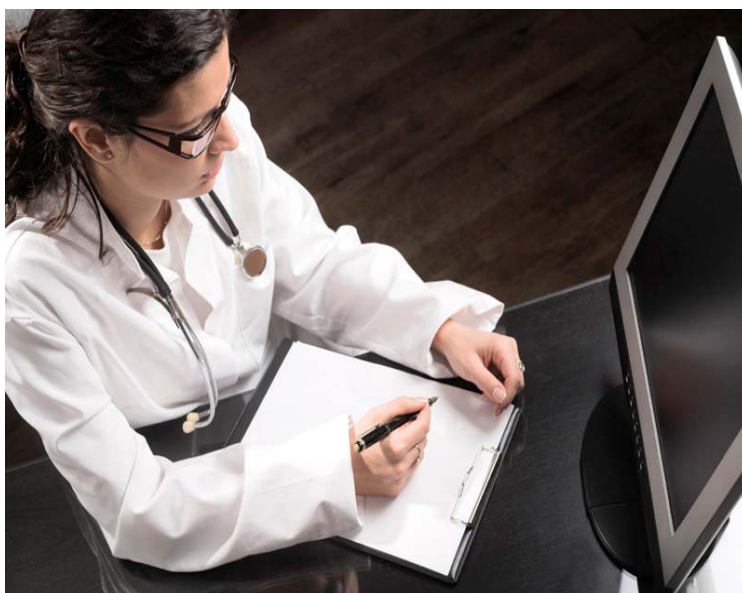
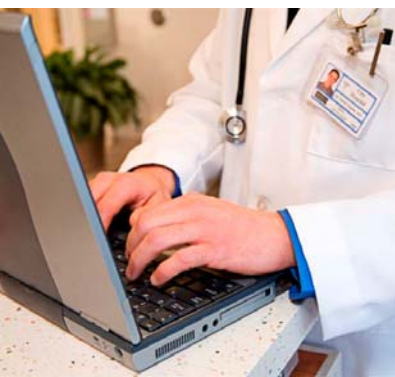


# Practical Guide for Clinicians

## Surgical Oncology

### The Tools and Information to Track Wait Times



**Wait Time Information System**



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# Surgical Oncology

## 1. About This Guide

This guide provides important information about the Wait Time Information System (WTIS) and the tools needed to use it effectively. The Oncology WTIS procedure categories, Priority Assessment Tools (PATs) and case studies are included in this document to support your understanding of the WTIS. The reporting categories, PATs, and case studies were developed by the Surgical Oncology Clinical Lead, Dr. Jon Irish, with guidance from his Clinical Expert Panel.

This guide contains Oncology specific WTIS information; there are guides for each WTIS surgical specialty (listed in the Appendix), which also include the Oncology WTIS procedure categories and Priority Assessment Tools (PATs).

### WTIS Oncology Update- Information You Need to Know

All surgical procedures for known or suspected cancer performed on adult patients in a fully-equipped operating room must be captured in the WTIS under Surgical Oncology.

As of December 1<sup>st</sup> 2008, you will notice the following modifications in the WTIS for the Oncology Service Area:

1. A minor word change will occur in descriptions of the Oncology Priority Assessment Tool (PAT)
  - The word change was designed to emphasize that most cancer cases should be a Priority 3

New Oncology PAT descriptions (changes are italicized):

Priority	Descriptions	Access Target
1	▪ Immediate – emergency surgery required	Within 24 hours
2	▪ Patients diagnosed with <i>highly aggressive malignancies</i>	Within 14 days
3	▪ All patients with known or suspected invasive cancer that does not meet the <i>criteria of Priority 2 or Priority 4</i>	Within 28 days
4	▪ Patients diagnosed with <i>indolent malignancies</i>	Within 84 days

2. Surgeons will only be required to prioritize treatment cases using the Oncology PAT
  - All diagnostic cases (surgical procedures required for staging and/or biopsy procedures required for diagnosis) will automatically be assigned a 14 day access target (Priority 2)
  - Priority assignment will continue to not be required for palliative or reconstructive surgeries

For diagnostic surgical procedures where there is a reasonable expectation of cancer, there is insufficient information to appropriately prioritize patients. For this reason, all diagnostic surgical procedures performed in a fully-equipped operating room for suspected cancer will automatically be assigned a 14 day access target in the WTIS. Wait times for surgical procedures where there is an extremely low probability of cancer should not be captured



under Oncology. For example, a thyroidectomy for a long standing multinodular goiter or for a thyroid mass where the diagnostic biopsy is benign and the growth behavior is minimal with a very low probability of cancer should be captured either under the General Surgery or the General Otolaryngology Surgery Service Area, depending on the specialty of the performing surgeon.

### **WTIS Reporting Requirements**

To meet the WTIS reporting requirements, clinicians and their staff are required to input the following data elements for surgical procedures performed in a fully equipped operating room:

- Patient demographics
- Procedure category (or Service Detail)
- A priority level using the appropriate Priority Assessment Tool (PAT)
- If applicable, dates the patient is not available for surgery

In the WTIS, surgical procedures can be reported under the following Service Areas:

- Adult surgery for your primary specialty: for all benign surgical cases performed on adult patients
- Oncology: for procedures for known/suspected cancer performed on adult patients\*
- Paediatric surgery for your primary specialty: for all procedures performed on patients less than 18 years of age, or under the age of 23 (at the discretion of the surgeon) for underlying congenital, developmental, or genetic disorders\*\*

\*Wait times for surgical procedures where there is an extremely low probability of cancer should be captured under the appropriate adult or paediatric Service Area.

\*\* Paediatric oncology procedures are reported under the Paediatric Service Area that corresponds to the performing surgeon's primary specialty. For example, a general surgeon reports paediatric oncology procedures under the Paediatric General Surgery Service Area.

### **Additional Information**

More about WTIS and some important definitions can be found in the Appendix. Any questions should be directed to your hospital's WTIS Coordinator or the WTIO Help Desk at [wtio@cancercare.on.ca](mailto:wtio@cancercare.on.ca) or 1-866-681-WTIO (9846).



## 2. Oncology - Adult

### Service Details

The WTIS procedure categories are organized in the WTIS Service Detail 1 and Service Detail 2 structure. The Surgical Oncology Priority Assessment Tool (PAT) is used to prioritize all surgical procedures performed in a fully equipped operating room for known or suspected cancer on adult patients.

Service Detail 1	Service Detail 2
Breast	Diagnostic, Palliative, Reconstructive, Treatment*
Central Nervous System	Diagnostic, Palliative, Reconstructive, Treatment*
Digestive System – Colorectal	Diagnostic, Palliative, Reconstructive, Treatment*
Digestive System – Esophagus	Diagnostic, Palliative, Reconstructive, Treatment*
Digestive System – Hepatopancreatobiliary	Diagnostic, Palliative, Reconstructive, Treatment*
Digestive System – Stomach	Diagnostic, Palliative, Reconstructive, Treatment*
Endocrine (Thyroid, Endocrine, Pancreas, Adrenal Pheo)	Diagnostic, Palliative, Reconstructive, Treatment*
Genitourinary (excluding Prostate)	Diagnostic, Palliative, Reconstructive, Treatment*
Gynaecological	Diagnostic, Palliative, Reconstructive, Treatment*
Head and Neck (excluding Thyroid)	Diagnostic, Palliative, Reconstructive, Treatment*
Lung	Diagnostic, Palliative, Reconstructive, Treatment*
Lymphomas	Diagnostic, Palliative, Reconstructive, Treatment*
Ophthalmic	Diagnostic, Palliative, Reconstructive, Treatment*
Peripheral Nervous System	Diagnostic, Palliative, Reconstructive, Treatment*
Prostate	Diagnostic, Palliative, Reconstructive, Treatment*
Sarcoma – Bone	Diagnostic, Palliative, Reconstructive, Treatment*
Skin – Carcinoma	Diagnostic, Palliative, Reconstructive, Treatment*
Skin – Melanoma	Diagnostic, Palliative, Reconstructive, Treatment*
Sarcoma – Soft Tissue	Diagnostic, Palliative, Reconstructive, Treatment*

\* Use Oncology PAT for Treatment cases only

### Oncology Priority Assessment Tool

Priority	Descriptions	Access Target
1	<ul style="list-style-type: none"> <li>Immediate - emergency surgery required</li> </ul>	Within 24 hours
2	<ul style="list-style-type: none"> <li>Patients diagnosed with highly aggressive malignancies</li> </ul>	Within 14 days
3	<ul style="list-style-type: none"> <li>All patients with known or suspected invasive cancer that does not meet the criteria of Priority 2 or Priority 4</li> </ul>	Within 28 days
4	<ul style="list-style-type: none"> <li>Patients diagnosed with indolent malignancies</li> </ul>	Within 84 days



## Case Studies - Adults

The following case studies have been developed by the Clinical Lead to assist you in understanding the PATs. Each case study provides a specific case example with relevant data, a recommended Priority Level and a supporting rationale.

### Endocrine (Thyroid, Endocrine Pancreas, Adrenal Pheo)

<b>Disease Entity</b>	Thyroid Cancer/Mass
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 30 year old woman presents with a solitary right thyroid mass.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>The thyroid mass has been present for 2 months and was initially found by the family physician. The ultrasound confirms a solitary mass and a needle biopsy shows follicular cells with no evidence of malignancy. There are no symptoms from the mass.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>The mass is asymptomatic and there has been no significant increase in size since onset. The mass measures 2-3 cm in size. There is no palpable lymphadenopathy. Vocal cord mobility is normal.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Endocrine (Thyroid, Endocrine Pancreas, Adrenal Pheo)

<b>Disease Entity</b>	Thyroid Cancer/Mass
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 55 year old woman presents with a solitary right thyroid mass.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>The thyroid mass has been present for 2 months and was initially found by the family physician. The ultrasound confirms a solitary mass and a needle biopsy shows cells suspicious but not diagnostic for papillary carcinoma. There are no symptoms from the mass.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>The mass is asymptomatic and there has been no significant increase in size since onset. The mass measure 2-3 cm in size. There is no palpable lymphadenopathy. Vocal cord mobility is normal.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Endocrine (Thyroid, Endocrine Pancreas, Adrenal Pheo)

<b>Disease Entity</b>	Thyroid Cancer/Mass
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 55 year old woman presents with a solitary right thyroid mass.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>The thyroid mass has been present for 2 months and was initially found by the family physician. The ultrasound confirms a solitary mass and a needle biopsy shows cells diagnostic for papillary carcinoma. There has been a recent voice change and a sensation of airway compression.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>There is a right vocal cord paralysis. The mass measures 4 cm in size. There is a palpable right supraclavicular and jugulodigastric node each measuring 2cm in size.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Head and Neck (excluding Thyroid)

<b>Disease Entity</b>	Oral Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 65 year old man presents with an oral cancer.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Patient presents with a 4 month history of a non-healing ulcer involving the left lateral tongue. Increasing pain and discomfort with some recent bleeding from the ulcer. No airway symptoms and his weight is stable.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>The patient has a 3cm ulcerative lesion involving the left lateral tongue. The lesion has about 1cm of depth and there is a palpable left level II node measuring 2cm is size. The patient has had an MRI confirming above finding.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Head and Neck (excluding Thyroid)

<b>Disease Entity</b>	Larynx Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 65 year old man presents with an advanced larynx cancer.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Patient presents with a 4 month history of a dysphonia and increasing dysphagia. Over the last two weeks there has been new onset mild stridor.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Patient has a large mass involving the right glottis and supraglottic with extension to the left side. There is right hemilaryngeal fixation and reduction in left glottic mobility. There is a palpable right level III node measuring 2cm in size. CT scan imaging shows extralaryngeal extension. The patient has been seen in a combined multidisciplinary clinic and primary surgery has been recommended.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Colorectal

<b>Disease Entity</b>	Obstructing Sigmoid Colon Adenocarcinoma
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>85 year old woman</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Presents to ER with 3 day history of obstipation, vomiting and abdominal pain. Pain requires IV narcotics. Unable to tolerate oral intake.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Significant abdominal tenderness, significant dehydration, evidence on imaging of complete large bowel obstruction.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 1 (Access Target: immediate)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>



### Digestive System - Colorectal

<b>Disease Entity</b>	Near Obstructing Adenocarcinoma of the Ascending Colon
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>56 year old man</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Presents for colonoscopy, several weeks of crampy abdominal pain. Change in bowel habit with increasing frequency of stooling and tenismus. Has had some minimal rectal bleeding. Referred by his family physician.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Activities of daily living impacted by frequency of stool. Cramps and pain limiting food intake with a significant weight loss. Fatigue secondary to anemia. Lesion found in ascending colon, unable to pass scope beyond. Near obstructing lesion but not completely obstructed.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Colorectal

<b>Disease Entity</b>	Rectal Adenocarcinoma
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>65 year old man</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Diagnosed with rectal carcinoma uT3N1M0 and has completed neoadjuvant treatment, has waited the optimal time following neoadjuvant for surgery.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Mass on exam, responded to neoadjuvant, stage: uT3N1m0</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus: Optimal timing for resection following neoadjuvant is 6-8 weeks. If that time is prolonged sphincter sparing surgery may be less likely. 28 day wait beyond optimal timing may influence outcome of surgery.</li> </ul>



### Digestive System - Colorectal

<b>Disease Entity</b>	Adenomatous Polyp in Caecum
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>67 year old woman</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Presents for screening colonoscopy at advice of family physician. No previous endoscopy. No family history. Asymptomatic. Large caecal polyp which is not removable endoscopically. Biopsy demonstrates adenomatous polyp with high grade dysplasia can not rule out malignancy in remainder of polyp.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Asymptomatic</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Central Nervous System - Spinal

<b>Disease Entity</b>	Metastatic extradural spinal cord compression
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>50 year old woman with known breast cancer presents with a lytic lesion at T10.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Severe back pain, progressive lower limb weakness, loss of ambulatory function and sphincter dysfunction.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Objective loss of motor, sensory function in the lower limbs. Lower limb hyper-reflexia, loss of abdominal reflexes.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 1 (Access Target: immediate)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Level I Evidence—Patchell et al Lancet 2005</li> </ul>

### Central Nervous System - Spinal

<b>Disease Entity</b>	Metastatic spinal tumor
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>55 year old man with myeloma presents with a T8 vertebral compression fracture and unremitting back pain over 4 weeks.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Severe midthoracic back pain which is worse with movement.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Focal midthoracic kyphosis.</li> <li>Percussion tenderness midthoracic spine.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Level II—prospective controlled case series of vertebroplast/kyphoplasty.</li> </ul>

### Central Nervous System - Spinal

<b>Disease Entity</b>	Intradural, extramedullary spinal cord tumor with severe cord compression
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>40 year old with neurofibromatosis presents with a C7 intradural, extramedullary tumor with progressive quadriparesis.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Progressive arm/leg weakness with impairment of bladder control and reduced sensation.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Upper motor neuron pattern of arm and leg weakness with focal radicular dysfunction (C7 distribution).</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Level III evidence – expert opinion, case series</li> </ul>

### Central Nervous System - Spinal

<b>Disease Entity</b>	Intramedullary spinal cord tumor
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>40 year old man with an extensive midthoracic intramedullary tumor with surrounding edema and peritumoral cystic changes</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Impairment of walking. Bladder dysfunction. Numb chest and lower limbs.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Upper motor neuron pattern of lower limb weakness.</li> <li>Sensory loss (pain, temperature, proprioception).</li> <li>Neurogenic bladder.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Class III—expert opinion, case series</li> </ul>

### Central Nervous System - Spinal

<b>Disease Entity</b>	Aggressive, malignant primary spinal tumor (chondrosarcoma)
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>45 year old man with midthoracic back pain and progressive lower limb weakness.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Midthoracic back pain—wakes the patient up at night.</li> <li>Lower limb weakness, numbness.</li> <li>Midthoracic numbness in band-like distribution</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Percussion-induced midthoracic back pain.</li> <li>Upper motor neuron pattern of lower limb weakness.</li> <li>Sensory level-low thoracic region.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Class III—expert opinion, case series</li> </ul>



**Breast**

<b>Disease Entity</b>	Breast cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 55 year old woman needs a completion mastectomy and desires immediate breast reconstruction for positive margins after a previous resection for ductal carcinoma in situ.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

**Breast**

<b>Disease Entity</b>	Breast Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 55 year old woman presents with a diagnosis of a unifocal invasive ductal carcinoma based on an abnormal screening mammogram.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

**Breast**

<b>Disease Entity</b>	Breast Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 35 year old woman presents with a rapidly growing breast mass.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>The breast mass was noticed two weeks ago as she was weaning her 5 month old child from breast feeding. She also has noted it enlarging. She wishes breast conservation if possible.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>A 3cm mass is noted on physical exam and there is no associated lymphadenopathy. Mammogram, ultrasound, and tissue biopsy show a unifocal invasive ductal carcinoma in the medial portion of her average size breast.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

**General Patient Case vs Priority Level for Prostate and Testicular Cancer**

<b>PROSTATE</b>		
<b>Patient Type</b>	<b>Recommended maximum wait time</b>	<b>WTIS Priority Category</b>
High Risk: PSA > 20 ng/ml or Gleason score > 7 or $\geq$ T2	$\leq$ 28 days from decision to operate	P3
Intermediate Risk: PSA between 10 ng/ml 20 ng/ml	$\leq$ 60 days from decision to operate	P4
Low Risk: PSA < 10 ng/ml or Gleason score < 7 and T1-T2a	$\leq$ 90 days from decision to operate	P4
<b>TESTICULAR</b>		
<b>Patient Type</b>	<b>Recommended maximum wait time</b>	<b>WTIS Priority Category</b>
Orchiectomy	< 7 days from decision to operate	P1
RPLND stage 2	<14 days from decision to operate	P2
RPLND Stage 1	< 28 days from decision to operate	P3
RPLND - post chemotherapy	< 28 days from decision to operate	P3



## Prostate

<b>Disease Entity</b>	Prostate Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 61 year old man with a PSA of 4.9 ng/ml</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Generally healthy male; asymptomatic.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Ultrasound and biopsy confirmed a Gleason score 6 adenocarcinoma. A bone scan and CT found no metastatic disease.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Consensus document: recommendations for optimal surgical wait times for patients with urological malignancies; Canadian Journal of Urology June 2006</li> </ul>

## Prostate

<b>Disease Entity</b>	Prostate Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 50 year old man presents difficulty urinating</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>4 month history of difficulty starting his urination and poor urinary stream. Examination revealed masses in both lobes of prostate.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>The PSA was 18ng/mL and biopsy confirms Gleason (4+4) score 8 with disease in 8 of 12 cores. Clinical stage T2b.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Consensus document: recommendations for optimal surgical wait times for patients with urological malignancies; Canadian Journal of Urology June 2006</li> </ul>

### Genitourinary (excluding Prostate)

<b>Disease Entity</b>	Bladder Cancer (cystectomy)
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>50 year old woman hemostatic</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Severe pain, bleeding</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Muscle invasive tumour</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Consensus document: recommendations for optimal surgical wait times for patients with urological malignancies; Canadian Journal of Urology June 2006</li> </ul>

### Genitourinary (excluding Prostate)

<b>Disease Entity</b>	Renal Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>50 year old woman</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Incidentally found 2 cm lesion in kidney</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Consensus document: recommendations for optimal surgical wait times for patients with urological malignancies; Canadian Journal of Urology June 2006</li> </ul>



### Gynaecological

<b>Disease Entity</b>	Gynaecology Oncology: Ovarian cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>A 60 year old woman presents with increasing abdominal girth.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Initially assessed for vague dyspepsia and change in bowel habit 4 months previously, no diagnosis was made. She now presents with rapidly increasing abdominal girth and anorexia.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Moderate abdominal distension with obvious ascites, a palpable, mobile, irregular pelvic mass.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus: Progression of ascites can lead to respiratory embarrassment.</li> <li>Optimal primary surgical de-bulking (followed by IP and IV chemotherapy) offers highest likelihood of cure and optimal likelihood of highest quality and longest duration of remission.</li> </ul>

### Gynaecological

<b>Disease Entity</b>	Gynaecology Oncology: Uterine sarcoma
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>55 year old post menopausal woman</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Presented to ER with heavy vaginal bleeding requiring transfusion. Endometrial biopsy shows uterine sarcoma.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Enlarged firm uterus; no evidence of ascites or extru uterine disease.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus: Definitive treatment for bleeding.</li> <li>Likelihood of cure diminishes significantly if disease spread beyond uterus.</li> </ul>

### Gynaecological

<b>Disease Entity</b>	Gynaecology Oncology: Cervical cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>38 year old woman</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Inter menstrual and post-coital vaginal bleeding.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Visible &amp; palpable cervical tumor measuring 3 cm in diameter; confined to cervix. Biopsy shows G2 squamous cancer of the cervix.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus: Intervene when there is no evidence of parametrial, nodal or other extra-uterine disease. Size of tumor directly related to likelihood of extra-uterine disease.</li> </ul>

### Gynaecological

<b>Disease Entity</b>	Gynaecology Oncology: Pelvic Mass
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>48 year old woman found on routine examination to have a right adnexal mass.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>8cm mobile adnexal mass which on ultra sound has solid components and multiple mural nodules. Ca 125 is reported at 359.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 or 3 (Access Target: within 14 or 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus: High likelihood of ovarian cancer; progression from early to late stage significantly reduces likelihood of cure.</li> </ul>

### Digestive System - Esophagus

<b>Disease Entity</b>	Thoracic Oncology
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>55 year old man</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Dysphagia to solids and liquids. Barium, swallow and CT scan detect esophageal mass with no mediastinal lymphadenopathy.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Dehydration</li> <li>Esophageal cancer</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Lung

<b>Disease Entity</b>	Thoracic Oncology
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>65 year old woman, smoker</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Asymptomatic 2 cm SPN (solitary pulmonary nodule), biopsy confirms non-small cell lung carcinoma.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

## Lung

<b>Disease Entity</b>	Thoracic Oncology
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>80 year old woman</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Massive hemoptysis, shortness of breath.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Right mainstem occluding tumour.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 1 (Access Target: immediate)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

## Lung

<b>Disease Entity</b>	Thoracic Oncology
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>45 year old woman</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Asymptomatic, lung abnormality detected on routine chest x-ray.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>CT scan shows fibrous (low grade) tumour of the pleura.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Hepatopancreatobiliary

<b>Disease Entity</b>	Bleeding hepatoma
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>55 year old man with HCC and 8 cm bleeding hepatoma in left lobe of liver.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Moderate abdominal pain</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Two episodes of hypotension, BP 70/40 over past 72 hours</li> <li>Failed embolisation, continued intra-abdominal bleeding</li> <li>Total 6 units PRBC transfusion</li> <li>INR 1.2</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 1 (Access Target: immediate)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Hepatopancreatobiliary

<b>Disease Entity</b>	Pancreatic Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>55 year old man with 4 cm hypoechoic mass in the uncinate process closely abutting the right side of the SMV.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Mild anorexia</li> <li>5 kg wt loss</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Icteric, Total bilirubin 80</li> <li>Otherwise fit, able to tolerate a Whipple resection</li> <li>NOT STENTED</li> <li>No evidence metastatic disease on high quality contrast CT scan</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 2 (Access Target: within 14 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Hepatopancreatobiliary

<b>Disease Entity</b>	Pancreatic Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>55 year old man with 4 cm hypoechoic mass in the uncinate process closely abutting the right side of the SMV.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Mild anorexia</li> <li>5 kg wt loss</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>Icteric, Total bilirubin 80</li> <li>Otherwise fit, able to tolerate a Whipple resection</li> <li>STENTED</li> <li>No evidence metastatic disease on high quality contrast CT scan</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Hepatopancreatobiliary

<b>Disease Entity</b>	Pancreatic Cancer
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>60 year old woman with 4 cm hypoechoic mass in the tail of the pancreas suspicious for adenocarcinoma.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>Mild left upper quadrant pain</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>None</li> <li>Fit to tolerate a distal pancreatectomy</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Hepatopancreatobiliary

<b>Disease Entity</b>	Colorectal cancer liver metastases
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>60 year old man with 2 right lobe metastases in segments 5/8 (4.0 and 3.8 cm).</li> <li>Previous sigmoid resection for Stage III adenocarcinoma followed by adjuvant FOLFOX.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>CT abdomen as above. CT chest clear. Colonoscopy clear</li> <li>Fit to tolerate right hepatic lobectomy.</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 3 (Access Target: within 28 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

### Digestive System - Hepatopancreatobiliary

<b>Disease Entity</b>	HPB Oncology-Branch Type Intraductal Papillary Mucinous Tumor
<b>Patient Demographics</b>	<ul style="list-style-type: none"> <li>60 year old woman with 4 cm cystic mass in the head of the pancreas.</li> </ul>
<b>Symptoms</b>	<ul style="list-style-type: none"> <li>None, incidental finding on abdominal ultrasound for renal colic.</li> </ul>
<b>Signs</b>	<ul style="list-style-type: none"> <li>None</li> <li>EUS confirms cystic mass with mural nodules</li> <li>Aspirate CEA 66, amylase 32, cytology indeterminate</li> <li>Fit to tolerate a Whipple resection</li> </ul>
<b>Recommended Priority Level</b>	PRIORITY LEVEL 4 (Access Target: within 84 days)
<b>Rationale/Evidence (if available)</b>	<ul style="list-style-type: none"> <li>Expert Panel consensus</li> </ul>

## Appendix

### Measuring the Wait Time

The WTIS is tracking the time from the decision-to-treat date until the procedure completion date. Dates affecting readiness to treat are removed from the calculation.

### Decision-to-Treat (DTT) Definition

The DTT is the date that both the clinician and the patient agree to treatment.

### Dates Affecting Readiness to Treat (DART) Definition

DARTs are non-health system related factors affecting the patient's readiness to treat. The WTIS provides a drop-down list of eligible DARTs, for example the patient's medical status has changed, a developmentally appropriate wait, and neo-adjuvant chemotherapy.

### Data Entry Requirements

Wait list entries must be created in the WTIS within two business days of decision-to-treat (to open the entry) and closed within two business days of the procedure completion date. Required data are patient demographics, priority level, service detail, and DARTS.

### Clinical Leads

The Clinical Leads were appointed by Dr. Alan Hudson, Lead of Access to Services and Wait Time Strategy, to provide guidance around each of the surgical specialties captured by the WTIS. This includes advice on reporting categories, priority levels, access targets and clinical requirements. They meet on a quarterly basis with Dr. Hudson and Sharon Pfaff, Deputy CIO at Cancer Care Ontario, to advise on the overall Wait Time Strategy. See the table below for the Clinical Lead in each specialty area.

Specialty	Clinical Lead	Specialty	Clinical Lead
General Surgery	Dr. Ori Rotstein	Otolaryngic Surgery	Dr. Ronald Fenton
Gynaecologic Surgery	Dr. Guylaine Lefebvre	Paediatric Surgery	Dr. Charlotte Moore
MRI/CT	Dr. Julian Dobranowski	Plastic & Reconstructive Surgery	Dr. Dimitri Anastakis
Neurosurgery	Dr. James Rutka	Surgical Oncology	Dr. Jon Irish
Ophthalmology	Dr. Phil Hooper	Thoracic Surgery	Dr. Shaf Keshavjee
Oral & Maxillofacial Surgery and Dentistry	Dr. Gerald Baker	Urologic Surgery	Dr. Neil Fleshner
Orthopaedics	Dr. Jim Waddell	Vascular Surgery	Dr. Thomas Lindsay



## **Ontario's Wait Time Strategy**

The Wait Time Information System is the application used to capture data as part of the Ontario Wait Times Strategy. For more information about the Wait Time Strategy please go to [www.ontariowaittimes.com](http://www.ontariowaittimes.com).

## **Practical Guides for Clinicians**

Practical Guides have been developed for the following surgical specialties and are available through your hospital's WTIS Coordinator:

- General Surgery
- Gynaecologic Surgery
- Neurosurgery
- Plastic and Reconstructive Surgery
- Oral and Maxillofacial Surgery
- Ophthalmic Surgery
- Orthopaedic Surgery
- Otolaryngic Surgery
- Thoracic Surgery
- Urologic Surgery
- Vascular Surgery

