Disclaimer

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Pathway Considerations

- The family physician should be informed of all tests and consultations and usual ongoing care with the family physician is assumed to be part of the pathway.
- Clinical trials should be considered for all phases of the Prostate Cancer Treatment Pathway, where available.
- Therapies should be selected as appropriate for patients.
Prostate Cancer Treatment Pathway

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Low Risk (must include all of the following):
- T1-T2a
- Gleason Score ≤ 6
- PSA ≤ 10

Candidacy for Curative Treatment is Assessed (including comorbidities, life expectancy, patient preference)

Patient Not a Candidate for Curative Treatment

Patient a Potential Candidate for Curative Treatment

Active Surveillance
- Periodic PSA Test and DRE
- Periodic Biopsy

Guideline EBS #17-9 under development

Disease treated palliatively with appropriate therapies
- Refer to Metastatic/Secondary Recurrence Pathway (Page 7 of 7)

Watchful Waiting
- Frequency up to discretion of managing physician
- PSA Test, DRE, Imaging

As needed

Diverticulitis

Multidisciplinary Consultation, Consideration of Treatment Options

Urologist

Radiation Oncologist

MCC

Refer to:
- MCC Standards
- MCC Resources

Decision to Treat
- Assign wait time priority*

* For more information on surgical and radiation wait time prioritization, visit:

Ready to treat
- Assign wait time priority*

Radical Prostatectomy
- Open, laparoscopic or robotic-assisted
- Refer to EBS #17-3

And

- Optional Standard Pelvic Lymph Node Dissection
- Refer to EBS #17-3

External Beam Radiation Therapy

Pathology

Pathology and PSA levels reviewed

If pT3, surgical margins positive or persistent detectable PSA

Early referral advisable.
- Refer to EBS #3-17

Ready to treat
- Assign wait time priority*

Adjuvant Radiation Therapy
- Refer to EBS #3-12

Radiation Deferred

Follow-up / Surveillance
- Scheduling can vary.
- Managed by the treating physician.

Assessment and management of treatment-related adverse effects

PSA Test, DRE, Imaging

As needed

** NOTE: PEBC guideline 3-10 under development. Brachytherapy recommendations subject to change upon completion of the guideline.
Prostate Cancer Treatment Pathway

Intermediate Risk

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Candidacy for Curative Treatment is Assessed (including comorbidities, life expectancy, patient preference)

Patient Not a Candidate for Curative Treatment

Patient a Potential Candidate for Curative Treatment

Radical Prostatectomy
Open, laparoscopic or robotic-assisted
Refer to EBS #17-3
And
Recommended Standard Pelvic Lymph Node Dissection
Refer to EBS #17-3

Pathology
Pathology and PSA levels reviewed

External Beam Radiation Therapy
With or Without Neoadjuvant Androgen Deprivation Therapy (If Indicated)
Optimize bone health With or Without Brachytherapy**

Internal Risk

Meets neither criteria for low nor high risk disease

Multidisciplinary Consultation, Consideration of Treatment Options

Urologist

Radiation Oncologist

MCC

Refer to: MCC Standards MCC Resources

Ready to treat Assign Wait Time Priority*

Decision to Treat Assign wait time priority*

Follow-up / Surveillance Scheduling can vary. Managed by the treating physician.

PSA Test, DRE, Imaging
As needed

** NOTE: PEBC guideline 3-10 under development. Brachytherapy recommendations subject to change upon completion of the guideline.

Early referral advisable. Refer to EBS #3-17

Adjuvant Radiation Therapy Refer to EBS #3-17

Radiation Deferred

Intermediate Risk

Disease treated palliatively with appropriate therapies Refer to Metastatic/Secondary Recurrence Pathway (Page 7 of 7)

Watchful Waiting
Frequency up to discretion of managing physician

PSA Test, DRE, Imaging
As needed

Ready to treat Assign Wait Time Priority*

If pT3, surgical margins positive or persistent detectable PSA

Early referral advisable. Refer to EBS #3-17

Follow-up / Surveillance Scheduling can vary. Managed by the treating physician.

PSA Test, DRE, Imaging
As needed

Assessment and management of treatment-related adverse effects

And
http://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=8870
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High Risk
Any one of the following:
- T2c or higher Gleason score
- PSA > 20

And

Selected patients with nodal involvement

Candidacy for Curative Treatment is Assessed (including comorbidities, life expectancy, patient preference)

Patient Not a Candidate for Curative Treatment

Patient a Potential Candidate for Curative Treatment

Watchful Waiting
Frequency up to discretion of managing physician
PSA Test, DRE, Imaging
As needed

Radical Prostatectomy
Open, laparoscopic or robotic-assisted
Refer to EBS #17-3
And
Mandatory Standard Pelvic Lymph Node Dissection
Refer to EBS #17-3

Pathology
Pathology and PSA levels reviewed

External Beam Radiation Therapy
With Adjuvant with or without Neoadjuvant Androgen Deprivation Therapy
(If indicated)
Optimize bone health

Disease treated palliatively with appropriate therapies
Refer to Metastatic/Secondary Recurrence Pathway (Page 7 of 7)

Early referral advisable.
Refer to EBS #3-17

Follow-up / Surveillance
Scheduling can vary. Managed by the treating physician.

PSA Test, DRE, Imaging
As needed

Assessment and management of treatment-related adverse effects

Multidisciplinary Consultation, Consideration of Treatment Options

Urologist

Radiation Oncologist

MCC

Refer to: MCC Standards MCC Resources

* For more information on surgical and radiation wait time prioritization, visit:
And
http://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=8870

Decision to Treat
Assign wait time priority*

Ready to treat
Assign Wait Time Priority*

External Beam Radiation Therapy
With Adjuvant with or without Neoadjuvant Androgen Deprivation Therapy
(If indicated)
Optimize bone health

Follow-up / Surveillance
Scheduling can vary. Managed by the treating physician.

PSA Test, DRE, Imaging
As needed

Assessment and management of treatment-related adverse effects

Ready to treat
Assign wait time priority*

Adjuvant Radiation Therapy
Refer to EBS #3-17

Radiation Deferred

Ready to treat
Assign wait time priority*

Adjuvant Radiation Therapy
Refer to EBS #3-17

Follow-up / Surveillance
Scheduling can vary. Managed by the treating physician.

PSA Test, DRE, Imaging
As needed

Assessment and management of treatment-related adverse effects

Ready to treat
Assign wait time priority*

Adjuvant Radiation Therapy
Refer to EBS #3-17

Radiation Deferred

Ready to treat
Assign wait time priority*

Adjuvant Radiation Therapy
Refer to EBS #3-17

Follow-up / Surveillance
Scheduling can vary. Managed by the treating physician.

PSA Test, DRE, Imaging
As needed

Assessment and management of treatment-related adverse effects

Ready to treat
Assign wait time priority*

Adjuvant Radiation Therapy
Refer to EBS #3-17

Radiation Deferred

Ready to treat
Assign wait time priority*

Adjuvant Radiation Therapy
Refer to EBS #3-17

Follow-up / Surveillance
Scheduling can vary. Managed by the treating physician.

PSA Test, DRE, Imaging
As needed

Assessment and management of treatment-related adverse effects
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Prostate Cancer Treatment Pathway

Primary Recurrence

From Primary Treatment

If Radiation Therapy was Previously Administered: Clinical recurrence And/or Positive biopsy

Observation

Proceed to Metastatic / Secondary Recurrence Pathway (Page 7 of 7)

Individualized Local Salvage

If progression

Proceed to Metastatic / Secondary Recurrence Pathway (Page 7 of 7)

If Radical Prostatectomy was Primary Treatment without Adjuvant Radiotherapy: Detectable rise in PSA levels

Observation

Proceed to Metastatic / Secondary Recurrence Pathway (Page 7 of 7)

Suspicion for Recurrence

Early referral for salvage therapy (ideally PSA < 0.4 and appropriate for radical treatment)

Radiation Oncologist

Consideration to Proceed with Salvage Therapy Joint decision by Urologist and Radiation Oncologist

From Primary Treatment

Suspicion for Recurrence

Salvage Radiotherapy External Beam Radiation Therapy With or Without Androgen Deprivation Therapy (If indicated) Optimize bone health

If progression, proceed to Metastatic / Secondary Recurrence Pathway (Page 7 of 7)

* For more information on radiation wait time prioritization, visit: http://cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=8870

Ready to treat Assign Wait Time Priority*
Prostate Cancer Treatment Pathway

Metastatic / Secondary Recurrence

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1 There are various ways to arrive at this pathway. Patient management could be directed by Urologists, Radiation Oncologists, Medical Oncologists or other, depending on the route.
2 Selected patients with nodal involvement can be managed with the high risk / locally advanced pathway.
3 Secondary Hormone Manipulation may include: androgen, antiandrogen withdrawal, antiandrogen switch, LH-RH switch, ketoconazole, or steroids.

Secondary Recurrence

Metastatic

Any of the following:
Nodal Involvement
Evidence of Metastasis

Secondary Hormone Manipulation

Androgen Deprivation Therapy
Optimize bone health
With Induction Antineandrogen Therapy
Or

Orchectomy

Androgen Deprivation Therapy
Optimize bone health
With Induction Antineandrogen Therapy
Or

Orchectomy

Follow-up / Surveillance
Scheduling may vary. Managed by the treating health care provider.
PSA Test, DRE (if symptomatic), Imaging
As needed

If PSA rising and Testosterone at Castrate Levels
Response Evaluation
Frequency up to discretion of physician
PSA Test

If PSA rising and Testosterone at Castrate Levels
Response Evaluation
Frequency up to discretion of physician
PSA Test

If PSA rising and Testosterone at Castrate Levels
Castrate-Resistant Prostate Cancer

Follow-up / Surveillance
Scheduling may vary. Managed by the treating physician.
PSA Test, DRE (if symptomatic), Imaging
As needed

If progression:
- If asymptomatic
  Continue Androgen Deprivation Therapy
  (with or without antiandrogen therapy)
  Optimize bone health
- If asymptomatic with bone metastases
  Consider Early Referral
- If symptomatic
  Follow-up / Surveillance
Scheduling can vary. Managed by the treating physician.

Sequence of specialties and care is individualized

Ready to treat
Assign Wait Time Priority*

* For more information on radiation wait time prioritization, visit: http://cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=8870

For Systemic Therapy
First-line cytotoxic chemotherapy requires a regimen containing docetaxel
Bone-Targeted Therapy may include bisphosphonate zoledronic acid or denosumab
Additional palliative agents may include abiraterone or cabazitaxel

Footnotes:
a. For Systemic Therapy, first-line cytotoxic chemotherapy requires a regimen containing docetaxel
b. Bone-Targeted Therapy may include bisphosphonate zoledronic acid or denosumab
c. Additional palliative agents may include abiraterone or cabazitaxel