Optimal care pathway for men with prostate cancer

Quick reference guide

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for men with prostate cancer.*

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Prevention

The causes of prostate cancer are not fully understood, and there is currently no clear prevention strategy.

Risk factors

- Increasing age, especially for men over 50
- Family history of prostate cancer
- Genetic mutations (e.g. BRCA2 gene) or particular genetic conditions (e.g. Lynch syndrome)
- Race (e.g. high to low risk: African American > Caucasian > Asian and Hispanic/Latino)
- Certain dietary factors

Screening recommendations

Currently there is no organised population-based prostate cancer screening in Australia. Men (including asymptomatic men) may elect to have routine PSA testing, but their GP should first discuss the benefits and harms of the test with them.

Men aged 45–69 years who are at moderate risk (based on their family history) should be proactively followed up and can be offered PSA testing every 2 years.

Men aged 40–69 who are at high risk (based on their family history) should be counselled about their risk and can be offered PSA testing every 2 years.

PSA testing is not recommended for men who are unlikely to live another 7 years.

Men aged 50–69 who are without risk factors for developing prostate cancer may also consider PSA testing for early detection.

Checklist

☐ Screening benefits and harms discussed with patient
☐ Recent weight changes discussed and the patient's weight recorded
☐ Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
☐ Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
☐ Physical activity recorded
☐ Referral to a dietitian considered
☐ Referral to a physiotherapist or exercise physiologist considered
☐ Education on being sun smart considered

Step 2: Presentation, initial investigations and referral

Signs and symptoms for investigation

Most patients who present with prostate cancer are asymptomatic.

Some patients present with locally advanced disease and may have the following symptoms:

- obstructive or irritative urinary symptoms
- blood in the urine or semen.

A small percentage of patients present with metastatic disease and may have the following symptoms:

- back and bone pain
- leg swelling
- weight loss
- fatigue
- neurological symptoms including weak or numb legs or feet.

Checklist

☐ Signs and symptoms recorded
☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
☐ Patient notified of support services such as Cancer Council 13 11 20
☐ Referral options discussed with the patient and/or carer including cost implications

SECOND EDITION

Australian Government
Cancer Australia

Cancer Council

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Step 2: Presentation, initial investigations and referral continued

Initial investigations

- PSA level
- Measurement of the free-to-total PSA ratio
- Midstream urine test (to check for prostatitis)

The significance of rising PSA (free-to-total PSA ratio), even within the age-adjusted normal range, should be recognised, as well as a PSA that is at the high end of the normal range in younger men.

Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

Timeframe

The GP should have results and review the patient:

- **within 4 weeks** for symptomatic patients and those with an abnormal digital rectal examination (DRE) or a PSA ≥ 10 ng/mL
- **within 12 weeks** for asymptomatic patients (PSA < 10 ng/mL).

Urgent referral to a specialist is recommended for:

- symptomatic patients (including psychological distress)
- patients with radiological evidence of locally advanced or metastatic disease
- PSA > 50 ng/mL.

Asymptomatic patients should be seen by a specialist **within 4 weeks** of a persistently abnormal result being identified or a single PSA reading ≥ 10 ng/mL.

Step 3: Diagnosis, staging and treatment planning

Diagnosis and staging

The following tests may be performed to confirm a diagnosis:

- DRE (prior to biopsy)
- multiparametric MRI
- systematic and/or targeted prostate biopsy.

Implications of both a positive and negative biopsy result should be discussed with the patient before the biopsy. A prostate biopsy should not be offered on the basis of serum PSA level alone.

Staging investigations in patients with clinically localised disease should be based on their risk of metastatic spread (Gleason score, clinical stage, PSA) and provisional treatment intent. Tests may include:

- DRE assessment to evaluate T-stage
- CT abdomen-pelvis and bone scan (PSMA-PET/CT has been shown to have greater accuracy than conventional imaging for high-risk prostate cancers for assessing nodal or distant metastatic disease).

Genetic testing

For detailed information and referral guidelines for prostate cancer risk assessment and consideration of genetic testing, refer to the Royal Australian College of General Practitioners 2019 Genomics in general practice <https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Genomics-in-general-practice.pdf>.

Treatment planning

The multidisciplinary team should discuss all newly diagnosed patients with prostate cancer **before** starting treatment and **as soon as possible** after the initial specialist consultation.

Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Checklist

- ☐ Diagnosis confirmed
- ☐ Full histology obtained
- ☐ Performance status and comorbidities measured and recorded
- ☐ Patient discussed at an MDM and decisions provided to the patient and/or carer
- ☐ Clinical trial enrolment considered
- ☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- ☐ Patient referred to support services (such as Cancer Council) as required
- ☐ Treatment costs discussed with the patient and/or carer

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Step 3: Diagnosis, staging and treatment planning continued

Communication

The lead clinician's[1] responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from multidisciplinary meetings (MDMs).

Timeframe

Investigations should be completed **within 4 weeks** of the initial specialist appointment.

Step 4: Treatment

Establish intent of treatment

- Curative
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation

If curative treatment is considered, men should be strongly encouraged to have an opinion from both a radiation oncologist and urologist to make a fully informed decision about their preferred treatment option.

Care and treatment of localised or locally advanced prostate cancer

- **Watchful waiting**: some patients (e.g. those with other health issues who are not expected to live more than 7 years) should be regularly monitored and symptoms treated if they arise.
- **Active surveillance:** most men with low-risk prostate cancer should be regularly monitored for signs of disease progression so curative treatment can be initiated if necessary.
- **Surgery (radical prostatectomy):** may benefit some patients with localised or locally advanced prostate cancer and at least a 10-year life expectancy.
- **Radiation therapy (by external beam radiation therapy and/or brachytherapy)** may benefit patients with:
  - localised/locally advanced prostate cancer who have at least a 10-year life expectancy or have symptomatic disease
  - locally advanced disease who may benefit from multimodal therapy
  - a rising/persistent PSA or established local recurrence without evidence of metastatic disease following radical prostatectomy
  - those who have limited bone metastases.

Treatment of advanced or metastatic prostate cancer

- **Androgen deprivation therapy (ADT)** is the standard treatment. The timing of starting ADT is often related to balancing the risk of side effects against the unwanted effects of the disease.
- **Other systemic therapy** may benefit patients with metastatic disease, cytotoxic chemotherapy, novel androgen receptor signalling inhibitors, bisphosphonates and RANK ligand inhibitors.

Palliative care

Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

☐ Intent of treatment established

☐ Risks and benefits of treatments discussed with the patient and/or carer

☐ Treatment plan discussed with the patient and/or carer

☐ Treatment plan provided to the patient's GP

☐ Treating specialist has adequate qualifications, experience and expertise

☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required

☐ Early referral to palliative care considered

☐ Advance care planning discussed with the patient and/or carer

Timeframe

Surgery should be conducted / radiation therapy begin **within 3 months** of diagnosis or **within 4 weeks** if significant local symptoms are present.

ADT or other systemic therapy: Treatment should begin **within 3 months** of the diagnosis if asymptomatic, or **within 4 weeks** if symptomatic or extensive metastatic disease is present on imaging.

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[1] Lead clinician – the clinician who is responsible for managing patient care.
The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

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Step 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing
- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP.

Checklist

☐ Treatment and follow-up summary provided to the patient and/or carer and the patient's GP

☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required

☐ Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Patients with locally recurrent disease can present asymptomatically with a rising PSA, or with symptoms such as urinary symptoms. Symptoms such as pain, loss of energy or weight loss can occur in men with metastatic disease.

Treatment

Each patient should be evaluated as to whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and patient preferences.

Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

Checklist

☐ Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP

☐ Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required

☐ Advance care planning discussed with the patient and/or carer

☐ Patient referred to palliative care if appropriate

☐ Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

☐ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required

☐ Patient referred to palliative care

☐ Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.

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