Optimal care pathway for men with prostate cancer

Quick reference guide

Please note that not all patients will follow every step of this pathway:

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

Step 1

Prevention and early detection

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

Early detection

Risk factors include:

- increasing age
- family history of prostate cancer
- certain dietary factors
- race (men of Caucasian background are more at risk than Asian men).

Case finding: Men at higher risk (based on their family history) should be counselled regarding their risk. PSA testing should be considered.

Men in good health may consider tests for early detection after discussing the risks and benefits with their primary care provider.

Step 2

Presentation, initial investigations and referral

Signs and symptoms

- The majority of men presenting with prostate cancer have no symptoms.
- Syptoms of locally advanced disease may include irritation on urination, obstructive urinary symptoms and/or blood in the urine.

Initial investigations include:

- PSA level
- measurement of free-to-total PSA ratio.

The significance of rising PSA (i.e. 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.

Assessments by the general practitioner should be completed within one week.

Referral: The patient should be referred to a urologist within six to 12 weeks (without symptoms) and earlier if symptomatic.

Communication – lead clinician[1] to:

- explain to the patient/carer who they are being referred to and why
- support the patient/carer while waiting for specialist appointments.

Step 3

Diagnosis, staging and treatment planning

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

Diagnosis and staging:

- DRE (prior to biopsy)
- prostate biopsy
- with or without prostate magnetic resonance imaging (MRI).

The use of staging investigations in men 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
- isotope bone scans
- computed tomography (CT) scan and/or prostate MRI
- Interval reimaging (to determine the appropriate timing of androgen deprivation therapy (ADT).

Treatment planning: All newly diagnosed patients should be discussed by a multidisciplinary team before beginning treatment.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

Offer advice on how to access support from prostate cancer peer support groups and groups for carers; visit www.prostate.org.au for local area listings.

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

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 offered an opportunity for a second opinion in order to have a balanced view about the available treatment options.

Treatment of localised or locally advanced prostate cancer:

- **Watchful waiting:** some patients (for example, those with other health issues who are not expected to live more than 7 years) should be monitored and symptoms treated if they arise.
- **Active surveillance:** some 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 men with at least a 10-year life expectancy.
- **Radiation therapy by external beam radiotherapy (EBRT) or brachytherapy +/– ADT:** may benefit patients with at least a 10-year life expectancy.

Treatment of advanced prostate cancer:

- **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.
- For patients with metastatic disease, chemotherapy, second-generation anti-androgens, bisphosphonates and RANK ligand inhibitors may be of benefit.

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.

Communication – lead clinician to:

- discuss treatment options with the patient/carer including the intent of treatment as well as the risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

http://wiki.cancer.org.au/australia/Guidelines:Prostate_cancer/Management/Locally_advanced_and_metastatic.

Step 5

Care after initial treatment and recovery

Cancer survivors should be provided with the following to guide care after initial treatment.

Treatment summary (provided to the patient, carer and general practitioner) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided.

Follow-up care plan (provide a copy to patient/carer and general practitioner) outlining:

- medical follow-up required (tests, ongoing surveillance)
- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the patient/carer
- inform the patient/carer about late effects, secondary prevention and healthy living
- discuss the follow-up care plan with the patient's general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection: Most residual or recurrent disease will be detected by a rising PSA in asymptomatic men.

Treatment: Where possible, refer the patient to the original multidisciplinary team. Treatment will depend on the location and extent of disease, previous management and patient preferences.

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.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the patient/carer.

Step 7

End-of-life care

Palliative care: Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the patient
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.