Title: Guidelines for Nurse Led Assessment and Follow up of patients with stable Prostate Cancer

Author(s): Adapted from SET

Ownership:

Approval by: NIcaN Urology NSSG Group Approval date: 29th November 2013

Operational Date: Next Review:

Version No. 3 Supercedes N/A

Links to other policies Policy for consent to examination, Treatment and Care, European Association of Urologists (Feb, 2012) Guidelines on Prostate Cancer

1.0 INTRODUCTION / PURPOSE OF GUIDELINE

This document outlines the guiding principles for nurse led prostate cancer follow-up and should be closely followed. However these guidelines are only a foundation and it is recommended that nurses maintain their continuing education in this specialist area of care.

The aim of this guideline is to set a minimum standard for nurse led assessment and follow up of patients with prostate cancer which will:

- Enable the follow up of patients with prostate cancer who are on the watchful wait or hormone treatment pathway
- Promote the education of patients about their disease management and potential for self directed aftercare
- Monitor patient progress and enable detection of progression and refer to the appropriate Consultant Urologist
- Enable holistic assessment
- Identify late effects of treatment quickly, provide support and signpost to the appropriate service if necessary
- Inform patients about and refer them to specialists services that can help with their medical, practical, emotional and rehabilitation needs
- Support patients living with and beyond cancer
- Offer patients a choice of follow-up
1.1 Objectives

The objectives of this guideline are to improve and maintain standards of clinical practice and quality of care patients receive by:

- Providing evidence based guidance for establishing and maintaining a nurse led clinic for the assessment of patients with prostate cancer, promoting excellence in the care that is delivered
- Reducing variation in clinical practice and encouraging uniformity of practice
- Providing a framework from which individual practitioners can apply their own level of clinical expertise and competency
- To ensure that all patients entering the prostate cancer follow up service are on the appropriate risk stratified pathway (Appendix 5 & 6)
- Helping nurses and health care providers to make informed decisions, aiding the education process and reducing the risk of clinical negligence
- Identifying competencies for nursing care
- Aiding development of locally agreed guidelines
- Promoting audit

1.2 Background

The NHS is undergoing radical changes particularly in its approach to cancer. Traditional nursing roles are being challenged in a bid to meet the demands of the changing NHS climate. Prostate cancer follow up forms a substantial part of the urology outpatient workload. Nurse led clinics are becoming increasingly common, offering patients an alternative method of follow up either via more convenient clinics or the telephone. By developing these new roles and services, nurses are playing a key role in increasing patient choice, reducing waiting times, increasing accessibility to services and improving the quality of care.

New standards have been developed within the Cancer Services Framework that are intended to ensure that patients experience the best possible quality of life after treatment by:

- providing new models of follow-up which focus on health and wellbeing
- improving access to psychological support

2.0 DEFINITIONS/SCOPE OF THE GUIDELINE

These guidelines should be used by suitably trained health care professionals who are providing nurse led follow up to patients with prostate cancer. Patients will enter nurse led follow up services on a clearly defined follow up pathway following discussion at MDM.

Recommended exclusion criteria

- Patients who do not wish to be followed up by a nurse
- Patients who require adjuvant treatment in the form of radiotherapy or chemotherapy
- Patients with dementia/short term memory loss (unless meeting patients with carer present)
- Patients who develop resistance to Hormone Therapy during follow up and require referral to oncologist
- Patients deemed unsuitable for review at a nurse led clinic by the consultant in charge
3.0 ROLES/RESPONSIBILITIES

Implementation of these guidelines is the responsibility of those involved in nurse led follow-up of prostate cancer patients.

Accountability is a key concern for all registered nurses today. Professional accountability is defined as being responsible for your actions and for the outcomes of these actions as part of the framework of clinical Governance, which aims to provide good quality, cost-effective evidence based care (Tilley & Watson 2004)

Nurses need to be aware of their limitations as well as their clinical competence. If there are any areas in which they do not feel clinically competent to undertake an activity they should decline the activity until the appropriate learning and practice activities have been achieved to demonstrate competency (NMC 2008)

Nurses are responsible for ensuring their own educational preparation and experience to safely perform the role. They should maintain documented evidence of completion of continuing education and of demonstrating clinical competence

Competencies required for assessing patients with prostate cancer can be found in (Appendix 2)

4.0 KEY GUIDELINE PRINCIPLES

4.1 Key Policy Statement

The purpose of the nurse led clinic is to enhance the quality of care and to promote the health and well being of patients who have been treated for prostate cancer. The clinic will also facilitate the provision of emotional support for patients and their families/carers requiring the opportunity to discuss treatment or care options

Nurse led clinics have been shown to improve the quality of care in the following ways
- Provide continuity of care for patients and their family
- Provide information, education and support
- Be accessible to patients and their family
- Release consultant time to see more complex patients
- Apply the principles of transforming cancer follow up

A risk stratified model of aftercare in line with the National Cancer Survivorship Initiative will be utilised and patients will be stratified into different arms of the follow up pathway according to their staging and personal characteristics by the Consultant.

Risk stratified means that the clinical team and the person living with cancer make a decision about the best form of aftercare based on their knowledge of the disease, (what type of cancer and what is likely to happen next), the treatment (what the effects or consequences may be both in the short term and long term) and the person (whether they have other illnesses or conditions, and how much support that they feel they need).

This will include the ongoing follow up of patients who are clinically stable and are stratified into the relevant pathway

- Watchful waiting (Pathway 1)
- Active surveillance (Pathway 2)
- Raised PSA – negative biopsy (Pathway 3)
- Post radical surgery (Pathway 4)
- Post brachytherapy (Pathway 5)
- Post radical radiotherapy (Pathway 6)
4.2 Policy Principles

Patients with prostate cancer who are on the pathways outlined above will be risk stratified into a pathway as discussed below

- **Self-Care with Support and Open Access**
  - No routine outpatient attendances
  - Stable disease pattern
  - After treatment with curative intent
  - Holistic assessment completed and care plan agreed
  - Information and/or some form of educational intervention
  - Surveillance tests with results by post or phone co-ordinated by a provider
  - Ability to re access system with/without reference to GP

- **Shared Care** – where patients continue to have face to face or telephone contact with professionals as part of continuing follow up.
  - Planned follow up either as an outpatient or planned phone follow up
  - Clinical examination required
  - High clinical or individual risks identified (disease, treatment, person)
  - Multi professional input required
  - Patients with co-morbidities
  - Those who decline or are considered to be unable to self manage

4.3 Long-term follow-up

Definitive guidance on the long term follow-up for patients with prostate cancer is included within the pathways which are concordant with NICE and European Association of Urologists Clinical Management Guidelines on Prostate Cancer.

4.4 Telephone Review Protocol

A telephone review service enables the Clinical Nurse Specialist to follow up patients through an alternative route and thereby reduce unnecessary hospital appointments for patients who have stable disease and are not fit to travel.

This service will be offered to those patients referred to the nurse led clinic and a telephone assessment protocol will be utilised. See appendix 7

4.5 Holistic Needs assessment (HNA)

The HNA is used to identify and address patient’s needs and concerns. The HNA may build on action plans developed from previous assessments. The HNA should be conducted during the follow-up appointment. The patient or carer is encouraged to complete the form and the assessor uses this as a guide to explore their needs and collaboratively develop an appropriate action or care plan.

An agreed Holistic Needs Assessment (HNA) tool will be utilised within the aftercare pathways

4.6 Support information and education

The consultant or clinical nurse specialist should offer patients support information tailored to the individual. This should cover as a minimum:

- Disease Progression
- Fatigue
- Pain
- Urinary Symptoms
- Finances/benefits
4.7 Rapid Access Protocol

Prostate cancer follow-up is the responsibility of the MDT. All patients should be able to access the Consultant responsible for their care through the Urology CNS. Any patient that contacts the Urology CNS with worrying symptoms will be seen by a Consultant promptly. If necessary, their case should be discussed by the MDT.

4.8 Triage Protocol

Each patient will be able to contact the Urology CNS outside of scheduled follow up appointments. The Urology CNS will triage the patient on their concerns/issues to the most appropriate member of the Urology team or refer on to other agencies accordingly. Outcomes may include:

- Face to face consultant appointment promptly
- Face to face Nurse led clinic (where appropriate)
- Advised to contact GP
- Advised to attend the emergency department
- Signpost to other support agencies e.g. Citizens Advice Bureau (CAB), AHP, Counselling

Only clinical issues will result in a clinical appointment.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination
Urology Clinical Nurse Specialists
Urology Consultants
Oncologists

6.0 MONITORING

Monitoring of these guidelines is the responsibility of the Urology Nurse under the direction of the line manager

7.0 EVIDENCE BASE / REFERENCES

Evidence:

BAUN (2008) Guidelines for nurse-led assessment and follow up of men with stable prostate cancer British Association for Urological Nurses

http://www.ejoncologynursing.com/article/S1462-3889(05)00140-7/abstract

CSCIP (2005) Applying High Impact Changes in Cancer Care

Department of Health Cancer Action Team (2007) Holistic Common Assessment Of Supportive & Palliative Care needs for Adults with Cancer Assessment Guidance p19


Department of Health (2006) Modernising Nursing Careers: Setting the direction


National Cancer Survivorship Initiative (NCSI Vision) Jan 2010

National Institute for Health and Clinical Excellence (NICE) Prostate Cancer diagnosis and treatment http://guidance.nice.org.uk/CG58


Nursing and Midwifery Council (NMC): The Code: Standards of conduct, performance and ethics for nurses and midwives (2008)

Service Framework for Cancer Prevention, Treatment and Care (2011)


8.0 CONSULTATION PROCESS

Cancer Services User Forum
NICaN Regional Urology Group

9.0 APPENDICES / ATTACHMENTS

See attached
10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

- Major impact [ ]
- Minor impact [ ]
- No impact [ ]

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_________________________________________  Date:
Name
Title:

_________________________________________  Date:
Name
Title:

_________________________________________  Date:
Name
Title:

_________________________________________  Date:
Name
Title:
Appendix 1

Prostate Cancer Review Assessment Form

Name………………………………………………..
Unit No……………………………………………..
DOB………………………………

Consultant………………………… GP…………………………
Date:……………. Time……………….

Type of review: Telephone  □ Clinic Contact □
Treatment Pathway: Hormone Treatment □ Watchful Waiting □

Histology Gleason’s Score ……………….. TNM …………………

PSA

PSA Trigger……………………………………………………………………

Date of PSA…………...... Current PSA…………………………... Previous PSA…………………………...

PSA obtained from ECR…………………………………………

Record what was discussed with patient

Changes in Urinary Symptoms

Storage  Yes / No
Voiding  Yes / No
Pain  Yes / No
Haematuria  Yes / No

If yes to any of the above, please comment and record advice given

General Symptoms

Hot Flashes  Yes/No
Tiredness  Yes/No
Weight gain  Yes/No
Breast Pain  Yes/No
Bone pain  Yes/No
Sexual Problems  Yes/No
Change in bowel pattern  Yes/No
Additional comments

**Problems and concerns**

Has patient had a Holistic Needs Assessment  Yes/No

If yes, Date of HNA ..............................................................

Discuss resolution of any problems identified in previous HNA  □

Are there any new concerns  Yes/No

- Financial
- Psychological
- Information and Support

Please record any issues

**Follow up**

Nurse Led follow up 3 months yes/no 6months Yes/No

**Referral to:**

Urologist Yes/No
Oncologist Yes/No

Letter to GP □
Letter to Consultant □

Signature of CNS.................................
Appendix 2  

Competencies for Nurse-led Follow-up

Competencies required assessing patients with stable prostate cancer include:

- Advanced nurse practitioner/clinical nurse specialist having been employed for a minimum of twelve months working with a urologist/oncologist in the follow up setting

- Demonstrate a full understanding of the network site specific group pathways for prostate cancer. As agreed by the local tumor network

- To be enrolled in or be undertaking, a programme of study in their specialist area of nursing practice which has been accredited for at least 20 CAT points at level 3 (DH2004) e.g. Health Assessment module

- Have advanced communication skills – to have enrolled in, or be undertaking a recognised course/module in communication skills (DH 2004)

- In order to run a clinic the individual must be a core member or extended member of the urology multidisciplinary team

- To be able to demonstrate knowledge of the disease trajectory in Prostate Cancer

- To be able to demonstrate knowledge of risk stratified pathways

- To have competent consultation and symptom analysis skills. To have worked under supervision for a minimum of six months and have been deemed competent by the consultant urologist/oncologist

- To be able to demonstrate knowledge of the tests and investigation required during follow up of prostate cancer patients

- To be competent at performing DRE (if appropriate)

- To be competent in the assessment of lower urinary tract symptoms (LUTS) and facilitate onward referral to LUTS clinic is required

- To be competent in bladder palpation

- To be competent in the assessment of bladder emptying

- To demonstrate ability to advise on erectile dysfunction and know where and how to refer to appropriate service

- To be able to demonstrate knowledge of survivorship issues

- To be able to demonstrate knowledge of rehabilitation services

- Demonstrate knowledge of drugs and treatments used in prostate cancer including side effect
## Guideline for Nurse Led Assessment Protocol

### Actions

- **Discuss**
  - Nurse led clinic
  - History/treatment to date
  - Timeline for routine follow up such as PSA, DRE and Admission Profile

### Physical Examination

- Carry out physical assessment including:
  - Digital Rectal Examination (DRE)
  - International Prostate Symptom Score (IPSS) if required

### Symptoms

- Is the patient experiencing any symptoms:
  - Hot Flushes
  - Ask about pain – any new pain lasting more than a week (use locally agreed pain scale)
  - Weight loss/gain
  - Fatigue
  - Sexual dysfunction
  - Neurological symptoms – Numbness, tingling or odd sensations in limbs
  - Lower Urinary tract symptoms
  - Haematuria
  - Gynaecomastia
  - Change in bowel habit
  - Deterioration in renal function

- Is the patient experiencing any symptoms suggestive of local or metastatic disease:
  - Abdominal/Pelvic/Skeletal pain
  - Weight loss
  - Anorexia
  - Nausea or vomiting

### Tests and investigations

- PSA at each visit if rising discuss with consultant
- Admission Profile at each visit
- FBP at first visit
- Ultrasound renal tracts following discussion with Consultant

### Holistic Assessment

- Perform holistic assessment suggested tools:
  - Macmillan Concerns Checklist & Care-plan
### Information

Nurse to check information has been provided and tailored to the individual patient. This will include information about:

- Timeline for tests and investigations
- Survivorship programme
- Rapid Access to service
- Contact numbers
- What symptoms need to be reported
- Consequences and side effects of the treatment
- Holistic Assessment
- Rehabilitation services

### Rehabilitation

Discuss and offer referral to:
- Community Health and Well-being Clinics
- Signposting to other services

### Documentation

Care plan
Letter to patient
Letter to GP & referring consultant with copy of assessment form,

To include:

- Date and time of nurse consultation
- Patients identifiable details
- Diagnosis
- Treatment,
- Assessment summary,
- Most recent PSA reading
- Date of next nurse appointment
- Potential or actual problems identified during the consultation.

Adapted from BAUN (British Association for Urological Nurses) - Guidelines for nurse-led assessment and follow up of men with stable prostate cancer (2008)
# Problem Management Plan

This plan will help to identify the appropriate actions when there is a change in the patients condition/needs during nurse led assessment and follow-up of patients with prostate cancer.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Rise in PSA</td>
<td>Repeat PSA as determined by consultant</td>
</tr>
<tr>
<td>Lower urinary tract symptoms that are more bothersome to the patient</td>
<td>Refer to LUTS clinic Urinalysis to exclude UTI Refer or discuss with appropriate consultant</td>
</tr>
<tr>
<td>Haematuria</td>
<td>Exclude UTI Assess lower urinary tract symptoms Refer for investigations</td>
</tr>
<tr>
<td>Hot flushes</td>
<td>Give support and advice and discuss with consultant</td>
</tr>
<tr>
<td>Pain - new onset bone pain</td>
<td>Request investigations – bone profile, pain and neurological assessment(use locally agreed pain scale) Consider MSCC Appropriate referral to urologist/ oncologist for further management</td>
</tr>
<tr>
<td>Change in bowel habit</td>
<td>Assess asking about change in consistency regularly. Give advice or refer to specialist as appropriate</td>
</tr>
<tr>
<td>Weight loss</td>
<td>If unexplained weight loss refer to consultant. Refer to dietician if appropriate</td>
</tr>
<tr>
<td>Gynaecomastia</td>
<td>Discuss with consultant and if required refer to oncologist</td>
</tr>
<tr>
<td>Deterioration in renal function</td>
<td>Discuss and if appropriate refer back to urologist Assess for poor bladder emptying by post void residual scan Order USS of renal tracts if appropriate</td>
</tr>
<tr>
<td>Weight gain, fatigue general malaise and anaemia</td>
<td>Give advice Consider referral for physical activity programme Check haemoglobin and if below normal levels discuss with consultant</td>
</tr>
<tr>
<td>Sexual Dysfunction</td>
<td>Assess for erectile dysfunction Give advice and consider referral to ED clinic if appropriate</td>
</tr>
<tr>
<td>Psychological needs</td>
<td>At time of the assessment any psychological concerns identified through use of NICaN Concerns Checklist will be discussed with the patient. Refer as appropriate to: Health and well being clinics Support groups Counselling Service Clinical psychologist</td>
</tr>
<tr>
<td>Financial concerns</td>
<td>Refer to CAB</td>
</tr>
<tr>
<td>Information needs</td>
<td>Discuss information needs Give written information if appropriate Consider onward referral if required Refer to Macmillan Information and Support Centre</td>
</tr>
</tbody>
</table>

Adapted from BAUN (British Association for Urological Nurses) - Guidelines for nurse-led assessment and follow up of men with stable prostate cancer (2008)
Prostate Cancer: Watchful Wait

Pathway 1

MDM (post completion of staging) plan recorded on CaPPs

Review by Clinician +/- CNS
Results & management plan discussed
PSA triggers (individual) agreed and documented
Treatment Summary record issued
(Copy to GP + CNS +/- patient)

3 month CNS Review appointment
Holistic needs assessment
Shared care pathway and rapid access to services explained
Caring for yourself leaflet given
Refer to Macmillan Information and Support Manager
Health and Well-being Clinic to be offered
*CNS secretary requests patient to get PSA checked by primary care one week before appt

6 month CNS Review appointment
Face to face / telephone / remote
History & PSA result
Signpost to other services if appropriate
Book appt for next review clinic in 6 months

PSA stable
PSA breach
Change in clinical status

CNS letter to GP & patient
PSA rechecked
Stable
Breach confirmed

6 monthly CNS review
Monitor PSA
Face to face / telephone / remote

Fast track to consultant for discussion / review
Clinician / CNS dictates letter regarding treatment decision to patient & GP & copy to CNS

Referral to oncology
Refer to MDM
Hormone therapy

Watchful waiting – Adapted from NICE Guidance 2008
‘Watchful Waiting is the form of continued review of Prostate Cancer patients for whom future therapeutic intervention with curative intent has been considered to be inappropriate’. 
Pathway 2
Prostate Cancer: Active Surveillance

MDM (post completion of staging)
Individually plan recorded on CaPPs

Review by Clinician Urologist +/- CNS
Results & management plan discussed
PSA triggers (pre agreed at MDM) documented
Treatment Summary record issued
(Copy to GP + CNS +/- patient)

3 month Clinician / CNS Review appointment
Holistic needs assessment, Shared care pathway explained
"Caring for Yourself" leaflet given, Patient requested to have PSA checked in primary care one week prior to appointment

6 month Clinician / CNS Review appointment
History, DRE, PSA result, Signpost to other services if appropriate
Book appointment for next review clinic in 3 months

9 month Clinician +/- CNS review appointment
Remote / telephone / face to face, History & PSA result
Book appointment for 1 year review

1 Year Clinician +/- CNS review appointment
Face to face, History, DRE, PSA result,
Recommend & arrange rebiopsy and restaging

MDM discussion & restaging (if necessary)

Therapeutic intervention
Radical surgery
Radical radiotherapy
Brachytherapy
Hormonal therapy

Active Surveillance –
Inclusion Criteria
Gleason 3+3 / 3+4
PSA < 10
Organ confined disease
Core tumour length <10mm
Maximum cores of 4 (G3+3)
Maximum cores of 2 (G3+4)

Continued Active Surveillance
including
3 monthly Remote PSA monitoring
6 monthly History, DRE,
2-3 yearly rebiopsy recommendation
PSA monitoring 6 monthly after 2 years

PSA breach

PSA rechecked

Stable

PSA breach confirmed

Fast track to clinician for discussion / review

Survivorship: www.survivorship.cancer-ni.net
Clinical Support Services: Education and Information: Physical Activity:
Other Support Services
Pathway 3  Raised PSA & Negative Biopsy

Negative biopsy report reviewed by Clinician or at MDM

Face to face / telephone appointment with Clinician or CNS
Give results and recommendations, correspondence to GP

Features of concern

Suspicion of malignancy
eg: family history, abnormal DRE, atypia, *HGPIN, **ASAP
high PSA density
Consider multi-parametric MRI.
If MRI abnormal consider PSA monitoring and / or re-biopsy

No Features of malignant concern and no LUTS

Discharge to GP with recommendations
Correspondence to GP and patient

LUTS
LUTS assessment

Continued monitoring
CNS or Consultant
Face to face / remote / telephone
To include regular PSA monitoring +/- DRE

Repeat biopsy / TRUS
Eg: template or saturation biopsies / targeted biopsies

Education of patients regarding PSA monitoring, alert symptoms and access to services

*HGPIN – High grade prostatic intra-epithelial neoplasia
**ASAP – Atypical small acinar proliferation
**Pathway 4**

**Prostate Cancer: Radical Surgery – Negative margins**

1. **Radical Prostatectomy performed regionally in BCH**

2. **6 weekly review with Urologist and CNS**
   - Results, PSA, Assessment, Follow Up Plan discussed, Treatment Summary completed
   - Copy to patient and GP

3. **3 month review with CNS**
   - Holistic needs assessment
   - Shared care pathway and rapid access to services explained
   - “Caring for Yourself” leaflet given
   - Refer to Macmillan Information and Support Manager
   - Health and Well-being Event to be offered
   - CNS advises patient to have PSA checked in primary care one week prior to appt

4. **6 monthly review with CNS for 2 years including;**
   - Face to face, telephone / remote, assessment of continence, ED, PSA, psychological issues, financial issues, returning to work etc.
   - (As per NICE Guidelines)

5. **Annual review with CNS for 3 years including;**
   - Assessment of continence, ED, PSA

   - **PSA undetectable**
     - Ongoing review as per protocol

   - **PSA detectable**
     - PSA rechecked
     - PSA detectable on 2nd check
     - MDM discussion
     - Refer to Oncology

6. **Discharge at 5 years with annual PSA checked through GP indefinitely. Re-referral guidelines provided for GP**
Pathway 5  Prostate Cancer: Permanent Prostate Brachytherapy (LDR)

Education of patients regarding PSA monitoring, alert symptoms and access to services

Permanent Prostate Brachytherapy Implant performed (Pt discharged)

Post implant AUR management if required

4 week Post implant CT scan and QA/peer review (PSA, IPSS, Dosimetry to database)

3 month - Radiographer telephone review (PSA to database)

6 month - Consultant led clinical review (PSA, IPSS, IIEF, EPIC to database)

6 monthly Consultant led clinical review.
   GP check PSA every 3-6 months
   (PSA, IPSS, IIEF, EPIC to database)
   Transfer to annual review at 3 years if PSA <1ng/ml & falling

12 monthly clinical review
   GP check PSA every 6 months
   (PSA, IPSS, IIEF, EPIC to database)
   Discharge to GP care at 5 years if PSA <1ng/ml & falling

GP information letter re biochemical and clinical triggers and re-referral pathway

Sigmoidoscopy by experienced practitioner at year 5, 10, 15 if deemed fit for procedure

Selection criteria for Permanent Prostate Brachytherapy

Clinical inclusion criteria:
- Organ confined prostate cancer T1 or T2
- Estimated life expectancy >10 yrs
- Gleason 6 and PSA <15ng/ml
- Gleason 7 and PSA <15ng/ml

Clinical exclusion criteria for brachytherapy:
- Prostate volume >50ml (>65ml prior to hormonal cytoreduction)
- IPSS >9. (Would consider for implant is <15 & Qmax >12ml/sec)
- Life expectancy <5 yrs
- Large or poorly healed TURP defect
- Unacceptable operative risk

Relative contraindications for brachytherapy:
- Large median lobe
- Previous pelvic irradiation

Clinical Support Services: Education and Information: Physical Activity:

Other Support Services

Survivorship - www.survivorship.cancerni.net

Selected men with:
- High volume Gleason 7 or
- Low volume Gleason >7 or
- Early T3a disease

May be suitable for dose escalation with combination therapy and should be referred for discussion to central brachytherapy team
Pathway 6: Prostate Cancer: **Radiotherapy±/-Hormones** *(Low Intermediate Risk)*

Radiotherapy delivered in NICC
PSA record card explained and issued.

**Consultant Review**
6 week post radiotherapy
PSA assessment, Assessment of side effects of XRT
Duration of hormone therapy discussed if relevant
Follow Up Plan discussed
Treatment summary record completed, copy to GP, patient and notes

**Consultant Review**
6 monthly review for 2 years with Oncologist or CNS where available
PSA assessment
Assessment of side effects of XRT

**Potential CNS Review**
Holistic needs assessment
Shared care pathway and rapid access to services explained
“Caring for Yourself” leaflet given
Refer to Macmillan Information and Support Manager
Health and Well-being Event to be offered
CNS/secretary requests patient to have PSA checked in primary care one week prior to appointment

Annual review year 3-5 with Consultant or CNS where available
PSA assessment
Assessment of side effects of XRT
Signpost to other services if appropriate
Book appt for next review clinic

- **PSA Stable**
  - Letter to GP and Patient
  - On-going review as per protocol

- **PSA Increase/trigger** *
  - PSA rechecked
  - Confirmed increase/trigger *

- **Clinical concern re recurrence/progression**
  - Fast track to consultant for discussion/review
  - Clinician/CNS dictates letter regarding treatment decision to patient and GP

Discharge to GP care at 5 years if PSA stable and testosterone within normal range.
Discharge letter and re-referral guidelines re biochemical* and clinical triggers

Sigmoidoscopy by experienced practitioner at year 5, 10, 15.
If deemed fit for procedure.

*Phoenix definition of Biochemical failure:
Absolute increase of 2.0ng/ml above the post treatment PSA

Low risk PSA<10 & G6 and T2
Intermediate risk PSA 10-20 or G7 and T2