



The role of the multidisciplinary team in urological malignancies



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Background : The uro-oncology Multidisciplinary team (MDT) alter management plans in about ¼ of cases. Additionally, MDT also serves other purposes, such as cross-referral or consideration for clinical trials [1]. In one study greater proportion of high – risk prostate cancer patients were evaluated at the multidisciplinary compared with urology clinic. However time from biopsy to radical prostatectomy (RP) was shorter for multidisciplinary clinic patients, no significant difference was found between the multidisciplinary and urology clinic in the risk of recurrence after RP [2]. A survey performed in the UK showed that some cases including low risk, non invasive bladder cancer and localised, low risk prostate cancer could be managed by pre-agreed pathways without full MDT review [3]. Patients should be discussed in MDMs if multimodal therapy may be required, clinical trial eligibility is being considered or if metastasis or recurrence is noted.

Aim : The aim of the study is to assess a benefit of MDT for treatment strategy in urological malignancies.

Material & Methods : Between 10/2014 – 02/2015, patients that were treated or followed at our department due to urooncological diagnosis, were reported within regular consultations. Standard clinical and histological parameters were registered. First a proposal of a referring physician regarding the further treatment was recorded and then compared with the MDT suggestion. The change between first proposal and MDT suggestion was compared with the physician's qualification. Respective further treatment and compliance with MDT were monitored. Spearman's correlation coefficient, contingency chart, chi-square test and Fisher's exact test were used for statistical evaluation.

Table 1. Study Group Characteristics

Number of cases; n:		176
Age; mean (±SD); min – max:		66,8y (±12,65); 28,3 – 91,9
Gender; n (%):	Males	145 (82.4)
	Females	31 (17.6)
Number of cases referred by; n (%):	Consultant	92 (52.3)
	Resident	84 (47.7)
History; n (%):	Primary tumours	103 (58.5)
	Recurrent tumours	73 (41.5)
Clinical stage; n (%):	Localized	115 (65.3)
	Locally advanced	26 (14.8)
	Metastatic	35 (19.9)
Type of surgery; n:	Radical Prostatectomy	27
	TUR	38
	Nefrectomy/resection	23
	Other	15
Radicality; n (%):	Positive surgical margins	63 (35.8)
Grade; n (%):	High grade tumours	81 (46.1)
	Low grade	95 (53.9)
Next process after MDT session; n (%)	Followed only	59 (33.5)
	Further treatment	92 (52.3)
	-Operation	38
Another department; n (%):	Referred to another dept	40 (22.7)
	-Radiotherapy	16
	-Chemotherapy	11
Compliance with MDT; n (%):		156 (88.6)

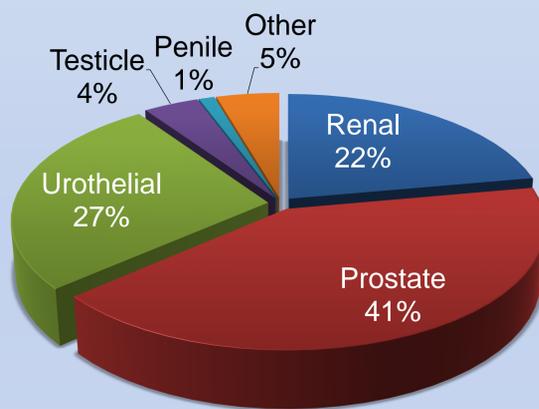


Chart 1. Tumour Types Distribution (176 cases)

Table 2. Results 1

PHYSICIAN OPINION CHANGE; n (%)			
	yes	no	p value
Primary	48 (46.6)	55 (53.4)	0.2245
Recurrent	41 (56.2)	32 (43.8)	
FURTHER TREATMENT; n (%)			
	yes	no	p value
Localized	53 (46.1)	62 (53.9)	0.2372
Locally advanced	15 (57.7)	11 (42.3)	
Metastatic	19 (61.3)	12 (38.7)	
FURTHER TREATMENT ACCORDING TO STAGE; n (%)			
	yes	no	p value
Primary	49 (47.6)	54 (52.4)	0.1684
Recurrent	43 (58.9)	30 (41.1)	
FURTHER TREATMENT ACCORDING TO GRADE; n (%)			
	yes	no	p value
High grade	51 (63.0)	30 (37.0)	0.0007
Low grade	21 (33.3)	42 (66.7)	
FURTHER TREATMENT ACCORDING TO CLINICAL STAGE; n (%)			
	yes	no	p value
Localized	61 (53.1)	54 (46.9)	0.0001
Locally advanced	21 (80.8)	5 (19.2)	
Metastatic	31 (100.0)	0	

Table 3. Results 2

CONFIRMATION OF OWN OPINION		
	Consultant	Resident
Own opinion confirmed	55 (59.8)	32 (38.1)
Opinion changed	37 (40.2)	52 (61.9)
p value	OR	95% CL
p = 0,0044	2,4155	1,3174 - 4,4292

Legend: MDT – multidisciplinary team, TUR- transurethral resection of urinary bladder

Results : Mean age was 67 years (28 – 92). Of the total number of 176 cases were 145 (82.4%) males. The study group comprised 73 prostate cancers, 39 renal tumours, 47 urothelial cancers, 8 other tumours, 7 testicular tumours and 2 penile tumours. Eighty-one cases were evaluated as high-grade (HG), 31 cases were metastatic and in 31 cases were positive surgical margins. A total of 84 cases was referred by a urology resident. In a total of 92 cases a further treatment was recommended : 19 radiotherapy, 38 surgeries, 8 hormonal therapy, 10 intravesical instillation, 17 chemotherapy. Forty patients were referred to another department. The own opinion on the matter was made more often by a board certified physician (p=0.0008). New treatment strategy was decided on more often (61.9 vs. 40.2%; p=0.0044) in cases referred by a resident. Follow-up at the Department of Urology was more frequent in localized or locally advanced tumour (p<0,0001). Subsequent treatment was more frequent in HG tumours (63.0 vs. 33.3%; p=0.0007). Patients with advanced tumours were referred more often to another department (p<0.0001).

Conclusion : The principal role of MDT is to determine the treatment strategy mainly in advanced or HG urological malignancies and in education of both residents and certified physicians.

References :

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