Is the multiprofessional-disciplinary approach to prostate cancer the answer to the complexity of the disease?

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Why is prostate cancer a complex disease?

Some examples:

- Epidemiology (the study of factors affecting the health and illness of populations):
  e.g. the recent explosion of incidence in some populations; temporal variations between the Western and Eastern worlds; causes and most of risk factors still unknown
- Natural history (a description of the uninterrupted progression of the disease in an individual from the moment of exposure to the causal agents until recovery or death):
  e.g. from "indolent" to "aggressive" diseases
- Primary prevention (trying to avoid the development of a disease):
  e.g. no primary prevention available

Why is prostate cancer a complex disease?

- Secondary prevention (aiming at detecting early disease, thereby increasing opportunities for interventions to prevent progression of the disease and emergence of symptoms):
  e.g. the critical aspects of PSA, not a specific tumor marker
- Diagnosis (the process of identifying a medical condition or disease by its signs or symptoms, and from the results of various diagnostic procedures):
  e.g. in general, no (cancer) sign or symptom present and radio-diagnostic procedures (TRUS, MRI, CT, PET) not always useful

Why is prostate cancer a complex disease?

- Therapy
  i.e. different treatment options for the same "state" of disease
- Side effects of different therapies (the different "weights" paid by patients for that specific treatment):
  i.e. quantitative and qualitative different impacts of treatments on physical, emotional and sexual domains
- Treatment decision (choosing the "best" option available):
  i.e. the decision making process should rely (relies) on patients

The complexity of the Decision Making Process (DMP)

Prostate cancer: different treatment options
"internationally accepted"

- Radical Prostatectomy
- External Radiation Therapy (± Hormonal Therapy)
- Brachytherapy (± Hormonal Therapy)

These three treatment modalities show similar clinical efficacy

The influence of treatment toxicities on the DMP

- Radical Prostatectomy:
  erectile dysfunction, urinary incontinence, infertility
- Radiotherapy:
  erectile dysfunction, rectal syndrome (rectal bleeding, fecal incontinence, etc), urinary symptoms, infertility
- Brachytherapy:
  erectile dysfunction, urinary symptoms, infertility
- Hormonal Therapy in combination:
  metabolic syndrome, loss of libido, feminilization (changes of muscle mass, decreasing of the penis size, increasing of breasts)

EAU Guidelines, 2007; AUA Guidelines 2007

The complexity of emotional and sexual side effects

Treatment(s) side effects can directly or indirectly cause significant consequences on personal and social relations.

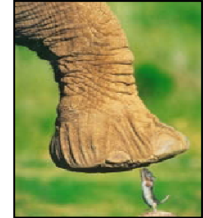
- modification of the body image
- loss of virility
- loss of libido
- distortion of one's sexual identity and masculinity
- emotional insecurity in the relation with the partner
- loss of self esteem
- isolation or limited sociality
- moodiness, anger, depression and apathy

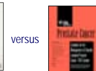
T D Denberg et al, Cancer, 2006
S Donegani, R Valdagni, Ann Onco (s)l, 2006
B A Weber et al, Geriatr Nurs, 2005

To further complicate the DMP: the "Active Surveillance" strategy

Aim. Low volume/ low grade/ low risk prostate cancer: as an alternative to radical treatments, the observational strategy called *"Active Surveillance",* to avoid both overtreatment and the potential side effects caused by therapies

However, ready to treat the patient when the disease changes its behaviour or the patient decides to undergo a curative treatment



versus 

Note:
AS should be considered an experimental approach
(EUA versus AUA guidelines)

L Klotz, Nature Clin Practice Oncol, 2008
N Nicolai and R Valdagni, EUA 2008
C Bangma et al, World J Urol, 2007

Interdisciplinary Strategies and Disease Complexity

- Prostate cancer:
  - ✓ three equally effective treatment options available for low/intermediate (± high) risk class disease
  - ✓ (for selected cases and within controlled studies, Active Surveillance can be proposed)
- If equally effective treatments are available, significant, qualitative and quantitative differences exist regarding side effects in physical, emotional and sexual domains

All this means
a radical change in physicians' and patients' attitudes when facing the Decision Making Process and the doctor-patient relationship

The complexity of the DMP

- The physician does not prescribe, rather he recommends the patient the possible, optimal therapeutic strategies

TREATMENT ALTERNATIVES

Standard. A patient with clinically localized prostate cancer should be informed about the commonly accepted initial interventions including, at a minimum, active surveillance, radiotherapy (EBRT and interstitial), and RP. A discussion of the estimates for benefits and harms of each intervention should be offered to the patient.
[Based on Panel consensus.]

- *The patient is asked to take the choice upon himself*, thus becoming active part in the decision process

The setting of physician-patient relation is therefore deliberative and no more paternalistic

E Falkum et al, Soc Science Med, 2001; R Valdagni et al, Int J Rad Oncol Biol Phys, 2005; S Donegani et al, Int J Rad Oncol Biol Phys, 2006; ME O'Rourke, Clin J Oncol Nurs, 2007

The difficulties encountered by the physician in the DMP and in the relation with the patient

Although the physician is repository of the scientific knowledge

1. He can feel displaced from his role and from his monospecialistic tasks, as he cannot propose a unique (the best) therapeutic approach
2. He can feel disoriented in the relation with the patient

Doctor: "The optimal therapeutic possibilities are more than one, and I am not in the position to tell you what is best for you …."

S Donegani et al, Ann Oncol, 2006

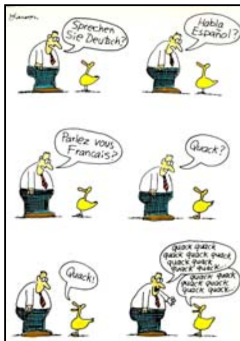
The difficulties encountered by the physician in the DMP and in the relation with the patient

1. The physicians involved in the early therapeutic phases (urologists, radiation oncologists, medical oncologists) are multiple and often "different" one from the other for education, specialistic cultures, approach to the patient and "historical tradition"
2. Different physicians might have different opinions which derive from uncertainties and ambiguities within the complexity of the disease and might end up disorienting the patients

P Abrahamsson, EAU EUE, 2007
A Fleissig et al, Lancet Oncol, 2006
R Valicenti et al, IJROBP, 2005

AR Kagan, IJROBP, 2005
FJ Fowler et al, JAMA, 2000
AE Chang, J Surg Oncol, 1998

The difficulties encountered by the physician in the DMP and in the relation with the patient



3. It's clearly hard for the single physician to explain analogies and differences among the three therapies exhaustively, objectively and polispecialistically

(F. L. Fowler et al, JAMA, 2000)

The difficulties encountered by the patient in the DMP

The patient is competent of himself, his values, the quality of his life but he is at the same time

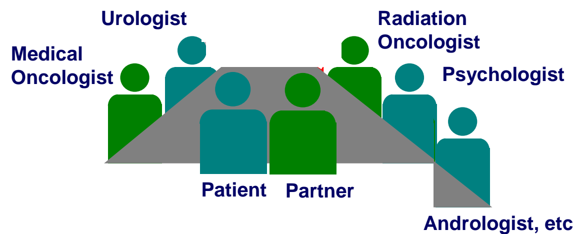
1. In need of relying on clear, unambiguous indications
2. Sometimes confused regarding the possibility of choosing the therapy

Patient: *"… I understand your point, doctor, but please help me: if I were your father, what would you suggest ?"*

3. Often little receptive of the technical-specialistic information (still worried about the diagnosis and prognosis)
4. Conditioned by personal concepts of health and disease, fantasies and misbeliefs related to the proposed therapies, personal or family's and friends' experience, information gathered from acquaintances and internet

S Donegani and R Valdagni, ASCO Prostate Symposium, 2006
S Donegani et al, Psycho-Oncology, 2006
AL Spatuzzi et al, EMUC Proceedings, 2007

So, how about adopting the Multidisciplinary approach systematically?



Modified from P. A. Abrahamsson, EAU E-U-E 2007

What are the aims of the Multidisciplinary Clinic?

1. To combine the different professional cultures and create synergies among the different physicians

2. To offer the patient a complete, simultaneous, unambiguous, polispecialistic counseling on his disease

D S Kaufman et al, NEJM, 2007
RK Valicenti et al, Sem Urol Oncol, 2005
R Valdagni et al, Int J Rad Oncol Biol Phys, 2005

R T Penson et al, The Oncologist, 2006
AR Kagan, Int J Rad Oncol Biol Phys, 2005
MM Sidhom et al, Lancet Oncol, 2006

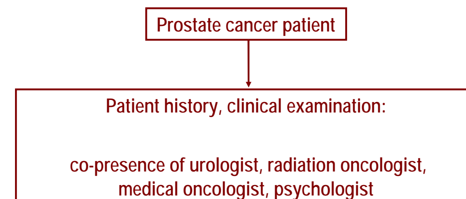
What are the Aims of the Multidisciplinary Clinic?

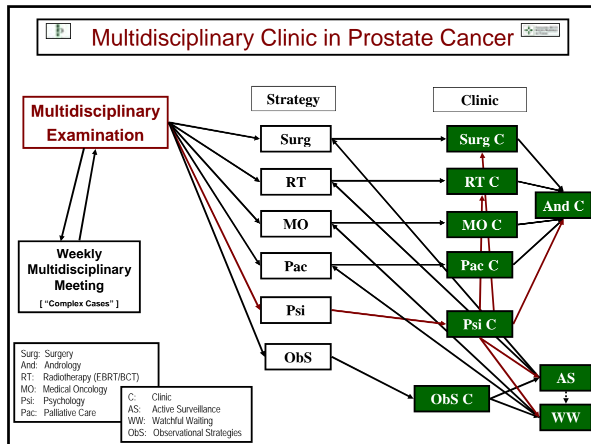
3. To offer detailed and satisfying explanations on analogies and differences on the proposed therapies and on the related side effects
4. To offer the "complex" patient a proper complete consultation, thus avoiding him the tour to different physicians
5. To offer the patient assistance and psychological counselling in the Decision Making Process

M Sidhom et al, Lancet Oncol, 2006
S Donegani et al, IJR OBP (s), 2006
J H Chang et al, Cancer, 2001
G Cook et al, J Interprof Care, 2001

INT Multidisciplinary Clinic in Prostate Cancer

(first clinical examination, second opinion)





The Multidisciplinary Clinic "outside the visiting room": The Weekly Multidisciplinary Meeting*

1. Creates the interspecialistic group culture
2. Creates an unambiguous language (shared guidelines)
3. Promotes the group's cultural growth
4. Enables the quality control of the procedures activated

* WMM
- New Case Presentations (examined the previous week)
- Follow up Discussion (active surveillance)
- "Complex" Case Discussion
- "Hot topics" related to new issues
- MDC organization and improvements, etc

The Multidisciplinary Approach: What do Patients think about it?

Pros
- Feeling of being taken care of holistically
- Satisfaction for the attention and the time dedicated to the single patient by every single physician
- Satisfaction for being active part in the decision making process
- Clear and no contradictory information

Cons
- Difficulty in identifying the different physicians and understanding one's role
- Need for a unique actor to handle discussion during the consultation
- Discomfort in being active part in one's decision making process

S Donegani et al, Int J Rad Oncol Biol Phys (s), 2006
R Valdagni et al, Int J Rad Oncol Biol Phys, 2005

The Multidisciplinary Approach: What do Physicians think about it?

Pros
- Possibility to face difficult situations taking advantage from the group's know how
- Chance to increase the know how through the discussion with the other physicians
- Satisfaction from the appraisal from the patients

Cons
- Difficulty to adopt a group attitude, that is discomfort in experiencing a reduction of one's freedom to accept and propose the opinion deriving from the group
- Risk of accepting leading opinions from one physician and of delegation of one physician to the group

S Donegani et al, Int J Rad Oncol Biol Phys, 2006
R Valdagni et al, Int J Rad Oncol Biol Phys, 2005

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Conclusion

1. The MDC appears to be the optimal (ideal?) approach:
   - ✓ facing the complexity of prostate cancer from the unabridged technical-scientific point of view
   - ✓ proposing the patient the optimal and more effective treatment option(s)
   - ✓ dealing with the complexity of the emotional dynamics lived by the patient
   - ✓ helping the patient make an aware, responsible decision, giving value to one's life priorities
   - ✓ considering the patient "subject of care", rather than only "object to cure"

The Multidisciplinary Clinic is Patient-centered

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Conclusion

2. However, the complexity of the dynamics within the multidisciplinary group and of the multidisciplinary group with the patient are beyond the simple sharing of a common space.

The set up of a Multidisciplinary Clinic:

- ✓ demands a training phase to help the physicians learn how to get familiar with the relational group attitude and overcome the habit of exclusive relations with patients (and collegues) and
- ✓ necessitates an attitude and availability to continuous education

Thanks for your attention