Prostate cancer: part one – multidisciplinary guidance

The management of men with all stages of prostate cancer is an increasingly complex process with a variety of available treatments and involvement of many different disciplines. In part one of a two-part series, **Drs Heather Payne, Nishi Gupta, Omar Al Salihi, Faye Lim** and **David Gillatt** discuss how the multidisciplinary approach is structured and the new management tools to provide the best treatment available for patients.

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It is now standard practice that every patient diagnosed with any malignancy or who has relapsed after treatment is presented in a regular site specific multidisciplinary meeting. Men with prostate cancer would be discussed in the urological oncology meeting.

The members of the team should include the following specialists:

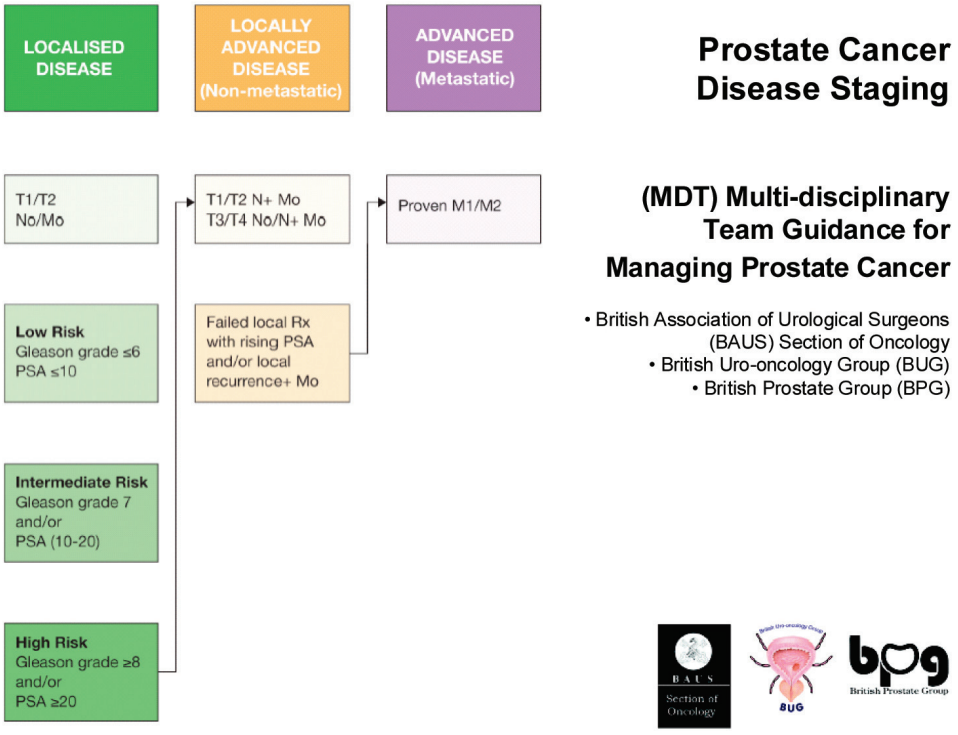
- a urologist, an oncologist and a pathologist to review and ratify the histological specimens;
- a radiologist to verify all imaging;
- oncology and urology clinical nurse specialists; and
- a multidisciplinary team (MDT) co-coordinator.

The concept of such integrated care is becoming increasingly accepted as a way to overcome fragmentation of patient management and provide a consistent treatment strategy across the MDT. It also creates an ideal structure to allow audit and peer review to take place.

The UK-based Integrated Care Network has stated that moving to an integrated practice can add value and improve a service in many ways (Integrated Care Network, 2004). The benefits can include an improvement in communication and in working relationships between members of different specialties with more positive staff responses and allegiances. It allows more robust arrangements for team working and leadership. The team can also utilise shared organisational structures in the form of support services, integrated management, innovative administration processes and emerging hybrid roles. It can also create new opportunities for investment, for example, in new IT systems and open access to new sources of funds.

The management decisions taken by such teams for individual patients can be complicated and evidence-based National Institute for Health and Clinical Excellence (NICE) guidelines for the management of prostate cancer are currently being written with publication due in 2007. In the interim it was felt there was a need for guidance to aid decision-making and in response to this representatives from the British Uro-oncology Group (BUG), the British Association of Urological Surgeons (BAUS) Section of Oncology and the British Prostate Group (BPG) have recently published an algorithm-based guidance tool for MDTs in managing men with prostate cancer. This new guidance tool will support MDTs in discussing the management and treatment options for the increasing number of men diagnosed with prostate cancer, now the most common cancer diagnosed in men in the UK. The guidance provides a quick reference to improve

Figure 1: Algorithm of the definition of prostate cancer stages.



consistency across prostate cancer management in a rapidly changing environment. Easy-to-follow algorithms for localised, locally advanced and metastatic disease summarise the detailed content of an evidence-based paper produced on CD (available by request to the authors). The treatment algorithm represent a management structure that goes beyond a simple co-coordinated system and will work most efficiently when the MDT is functioning as a single integrated unit.

This guidance combines the evidence base for best treatment, balanced with morbidity from therapies and consideration of the individual patient's varied needs and lifestyle.

The first algorithm (*Figure 1*) in this MDT guidance is a summary of the definition of prostate cancer stages. These are localised, locally advanced and advanced (metastatic) which have been staged according to the TNM (tumour, nodes, metastases) classification. Localised disease is further subdivided into low, medium and high risk categories in terms of pathological Gleason Grade and pre-treatment prostate-specific antigen (PSA). These risk factors play an important role in determining the treatment options for men, both in terms of the likelihood of the success of various primary therapies and also in the need for adjuvant therapies to treat undetectable microscopic metastases.

There are algorithms for each of these three major stages to aid management decision-making. Treatment strategies are influenced by the stage of the disease and by an interaction between the risk of disease progression, survival and key patient characteristics (eg, age, lifestyle and general health). Risk factors for progression in prostate cancer include pathological Gleason Grade and presenting PSA and PSA velocity. Other factors include any co-morbidities that may affect the outcome of treatment and the side effects associated with that treatment.

A list of relevant co-morbidities is listed at the top of every algorithm for consideration. It is important to consider the relevance of the following to each individual patient when trying to decide upon optimal treatment options: life

Key points

- The management of men with all stages of prostate cancer is an increasingly complex process with a variety of available treatments and involvement of many different disciplines.
- MTD meetings are important in determining the best evidence based treatment for the patient.
- The benefits of any treatment must be matched with associated morbidities relevant to the individual patient.
- An open discussion touching on quality of life issues and the impact of side effects is the key to achieving good patient satisfaction in terms of their management and care.

expectancy, sexual functioning, urinary symptoms and an IPSS score, bowel symptoms, bone pain and risk of osteoporosis. The discussion of these factors is of crucial importance in determining the most appropriate way forward. It is also of vital importance that the patient has the fullest possible role in determining treatment. Patient preference should be discussed within the multidisciplinary meeting (MDM) as well as any relevant family history.

The MDM should set the scene and determine the key issues for discussion between the clinician and the patient. These issues will include the survival prognosis and whether it is possible to offer a treatment with curative intent. For many men with prostate cancer, there may be a bewilderingly long list of therapy options and these must be described in terms of survival and disease-free progression outcomes. The decision of optimal treatment for any individual man must be balanced with the frequency and severity of any associated side effects and how these could interact with lifestyle and other co-morbid conditions. The impact and relevance of sexual function, bowel function, urinary function, physical strength and level of activity must be discussed. The psychosocial impact on the man and his family should also be considered.

A progress report of the NHS cancer plan was published in January 2006[1]. It stated that of the patients interviewed 34 per cent of prostate cancer patients reported that they had received information on relevant cancer support or self-help groups who could provide information and support. Also 20 per cent of patients had either not discussed or not fully understood potential pain and side effects associated with treatment and possible alternative or complementary treatments. These results show the need for improvement and better utilisation of the multidisciplinary approach. It has been demonstrated that men who incorporate quality of life considerations into their therapy decisions are likely to feel better about treatment choices, be more satisfied with their overall care and experience less regret. There is a lack of evidence to guide healthcare professionals on how to most effectively share clinical evidence with patients facing decisions. However, basing recommendations largely on related studies and expert opinion, it is possible to achieve these communication tasks when framing and communicating clinical evidence.

It is important that there is an understanding of the patient's experience, expectations and preferences – this can be used to build partnerships with the patient and carer. The MDT needs to provide evidence – including uncertainties – and discuss side effects with the patient before discussing any recommendations. There is a need to check for understanding and agreement.

The treatment approaches for each stage of prostate cancer will be discussed in a second article coming soon in *Geriatric Medicine*, highlighting current management approaches. It is suggested that patients referred to the MDT at diagnosis or relapse should have the management options outlined for each stage discussed with their individual needs, lifestyle and co-morbid factors taken into full consideration.

Conflict of interest: none declared.

References

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2. Barry MJ *et al*. Committee 13: Quality of Life. World Health Organisation Compendium, 2004