MDT’s and Treatment Guidelines influence better outcomes for patients

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Outline

- Variation in outcome of colorectal cancer care
- EURECCA
  European Registration of Cancer Care
- What is good colorectal cancer care?
- Guidelines
- MDT

5-6 July 2013, Barcelona
Historical notes on quality of care in rectal cancer

- Before the 1990’s local recurrence of rectal cancer was unacceptable high (20-60%)

**Improvement in time due to .....**
- Surgery
- Radiation therapy in rectal cancer
- Chemo therapy in colon cancer
- Pathology
- Radiology
- Audits
- Guidelines
- MDTs
Trends in mortality from CRC in selected countries

Globocan 2008
Eurocare-4 (95-99): age standardized 5yr relative survival

Sant et al. EJC 2009: 931-991
Large differences in outcome after treatment for colorectal cancer

Wide international variation in CRC survival between high income countries

313852 patients with CRC

- Australia
- Canada
- Denmark
- Norway
- Sweden
- UK lowest survival at one and three years

Do we strive for no variation?

Simply not possible!
Do we strive for no variation?

Each patient is different:

- Genetic backgrounds
- Tumour anatomy and biology
- Comorbidities
- Lifestyles
- Patient preferences

- Random variation ➔ not likely to be improved
- Reduce systematic variation due to differences in policies
How do we reduce variation in outcome?

- What endpoint(s) defines good care?
- Tradionally
  - *Survival, overall survival - disease free survival*
- Modern
  - *Quality of life*
  - *Functional outcomes ➔ sexual, urinary & gastrointestinal function*
- Shared decision making?
Your treatment, your goals

More patient interaction in decision making
Variation or transparency?

- Generalized data (averages of a population) → tailor made cancer management
- How do we monitor tailor made cancer care?
- When is cancer care transparent?
Are we good doctors?
How can we change treatment outcome?

- Become better doctors by registry and feedback
- Good monitoring and auditing; need to look at patient data
- High volume centers
- Keeping ahead of science → Up-to-date Guideline
- Research
- Learning from best practices, training
Every patient deserves the best care there is

- The mission of the European Cancer Organisation
- What is the best care there is?
- Dynamic field of knowledge… we need experts to lead the way
- Guidelines
THIS WAY
EURECCA
European Registration of Cancer Care

- Knowledge by registry and measurement
- Best and bad
Quality Assurance Project: an ESSO initiative

One European Cancer Audit

Quality  Variation

- Identify and spread Best Practice
- Research
- Outcome monitoring (feedback)
- Guidelines Development

5-6 July 2013, Barcelona
Guidelines

- Same pool of scientific evidence
- Many different national guidelines
- Consensus of international experts of all different fields of cancer care
EURECCA Objectives

- To perform research on registries
- To define “core quality treatment recommendations”
- To integrate “core treatment quality strategies” in clinical practice
- To optimize the level of knowledge and experience
December 2012 consensus conference
Colon & Rectum

- Delphi Method
- Diagnostics and treatment statement
- Expert panel
- Several voting rounds to establish minimal standards of good cancer care
Multidisciplinary collaboration
Results of the consensus process

465 statements on diagnostics and treatment colon and rectal cancer

- 75% of the experts voted
- 84% large consensus, >80% agree
- 6% moderate consensus, >70% agree
- 7% minimum consensus >50% agree
- Only 3% was disagreed by more than 50% of the members.

van de Velde et al. EJC xxx (2013) xxxx In press

Patient version in progress
Treatment strategy colon cancer

**CLINICAL STAGE**

1. cTis-T1 NxMx
   - EMR, EMA, ESD
   - MDT: Follow up

2. cT2N0M0
   - Colon resection
   - MDT: Follow up

3. cT3N0M0
   - Colon resection
   - MDT: Follow up

4. cT4N0M0
   - Colon resection
   - MDT: Chemo therapy

5. Any T, N+, M0
   - Colon resection
   - MDT: Chemo therapy

6. Any T, N+, M0
   - Colon resection
   - MDT: Chemo therapy

**MDT**

- pTis-T1 R0: Low risk
- pTis-T1 R1/2: High risk
- pTis-T1 N0
- pT2N0
- pT3N0
- pT3N+ or <10 LN: High risk
- pT4N0 R0
- pT4N+, <10LN: High risk, R1-2
- pN1-2

**Follow up**

- 1.1
- 1.2
- 1.3
- 2.1
- 3.1
- 4.1
- 4.2
- 5.1
- 5.2
- 5.3
- 6.1

**Chemo therapy**

- 5.4 RERESECTION
- 5.5 RADIATION
Consensus document

- Basis for diagnosis, staging and treatment guidelines in Europe
- To support MDT’s in medical decision making
- To be published soon in EJC van de Velde 2013
MDT

- multidisciplinary team
- radiation oncologist
- medical oncologist
- surgeon
- pathologist
- radiologist
- nurse specialist

Before and after intervention

5-6 July 2013, Barcelona
All new patients with cancer ➔ discussion of diagnostics and treatment by multidisciplinary board

Several moments in time treatment should be discussed in MDTs
- Preoperative/postoperative
- After neoadjuvant treatment and after adjuvant treatment

Hazards of good structured MDTs

- Time pressure, workload, reduced attendance
- Disagreement within MDTs
- Lack of open environment for discussion
- Team morale
Take home messages

- Anonymous patient data for monitoring the quality of cancer care showing doctors where to improve
- Anonymous patient data should be collected to learn from diagnostic and treatment decisions
- Patient versions of guidelines and consensus documents should be available for medical decision making
Take home messages

• Every patient should be discussed in several MDT sessions

• MDTs should adhere to the latest guidelines and consensus documents

• Decisions outside guidelines and consensus papers should be carefully discussed with the patient and described in the dossier

• Medical decision making should be preferably shared decision making between patient and her/his physician
Thank you!