

# National Prostate Cancer Conference

## Forward Together: Getting the Best for Men

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# Modelling Best Practice for Multidisciplinary Teams

Dr Chris Parker

# What is an MDT?

- Specialist MDT
  - At least 2 urologists
  - Clinical oncologist
  - Radiologist
  - Pathologist
  - Clinical nurse specialist
  - Palliative care specialist
  - Team co-ordinator

## Improving Outcomes in Urological Cancers, 2002



- *“I believe that the establishment of specialist cancer teams across the country has been one of the most important developments in recent years”*

Mike Richards, National Cancer Director, 2003

# The case for MDTs

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- To promote specialisation
- To reduce geographical variation
- To improve treatment decision-making

# The case for MDTs

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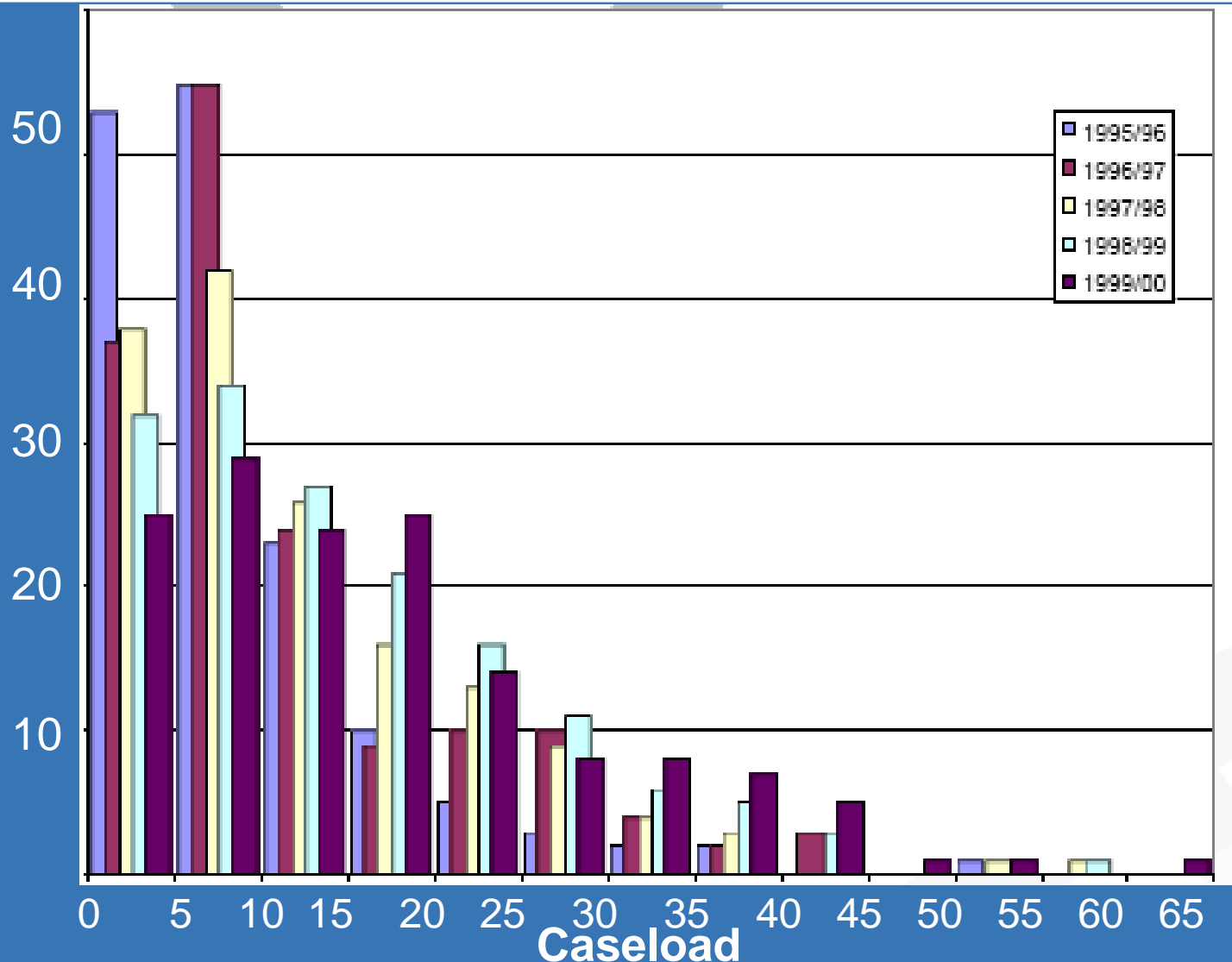
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# Role of Surgeon Volume in Radical Prostatectomy Outcomes

Hu et al. *Journal of Clinical Oncology*, 2003

	Surgeon volume		
	< 40 cases per year	≥ 40 cases per year	
In-hospital complications	22%	12%	p<0.01
Anastamotic strictures	27%	22%	p=0.17
In-patient stay	5.2 days	4.1 days	p<0.01

# Hospital caseload for prostatectomy/cystectomy



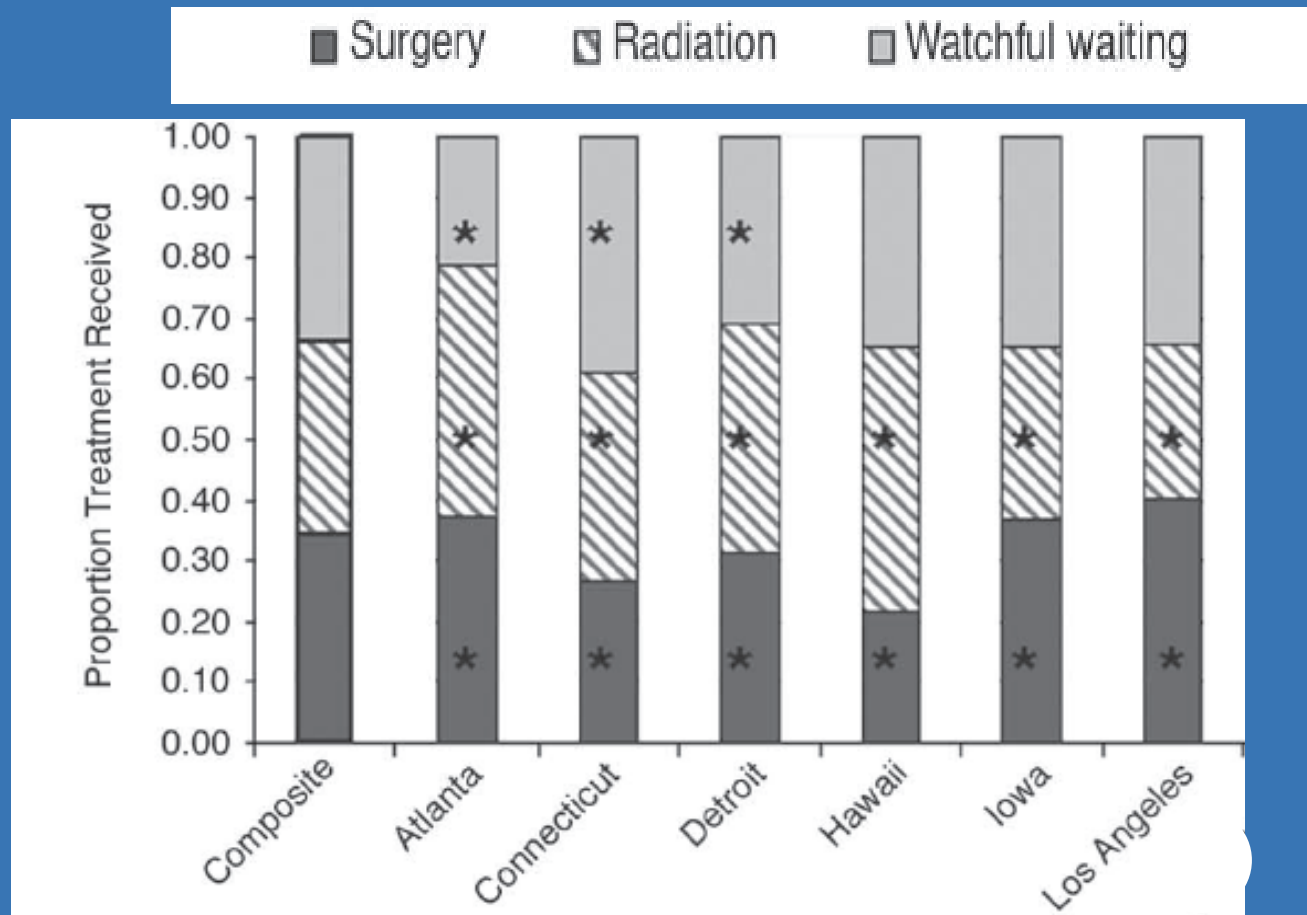
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# Geographic and Socioeconomic Variation in the Treatment of Prostate Cancer

Tracey L. Krupski, Lorna Kwan, Abdelmonem A. Afifi, and Mark S. Litwin



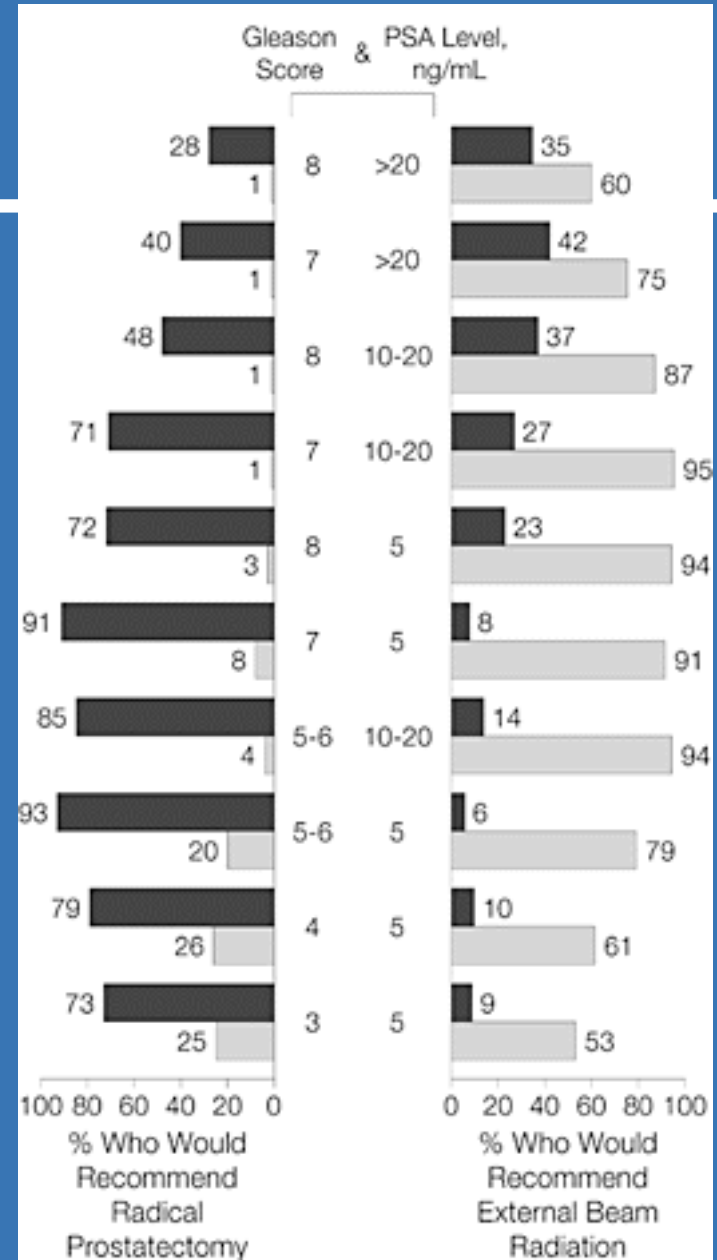
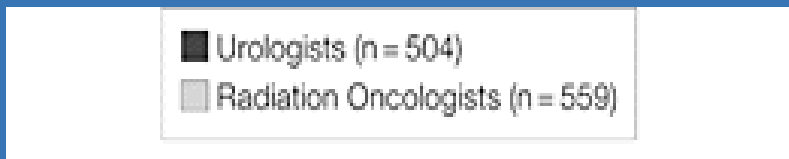
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# Comparison of Recommendations by Urologists and Radiation Oncologists for Treatment of Localized Prostate Cancer

Fowler et al. *JAMA*. 2000



# Building on the Best



## Choice, Responsiveness and Equity National Consultation

‘Patients want **more involvement** in decisions about their treatment....

This is the top priority for participants irrespective of age, gender, region or disability’

April 2004

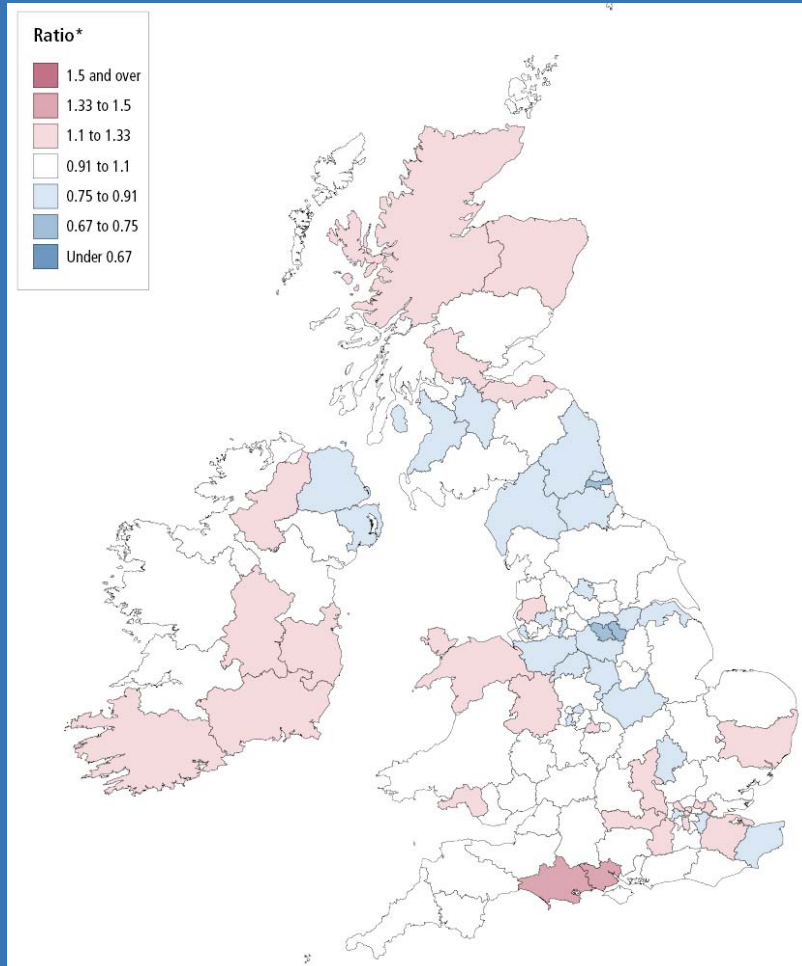
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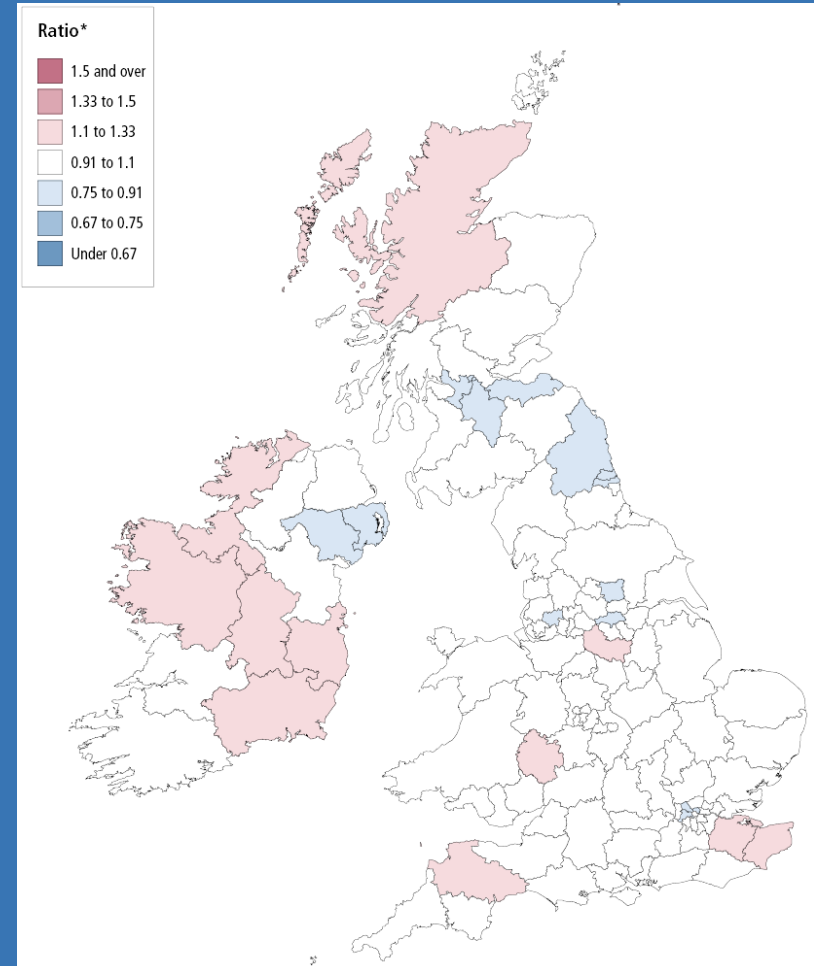
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# Geographical variation in prostate cancer incidence and mortality

## Cancer Atlas of the UK and Ireland



Incidence



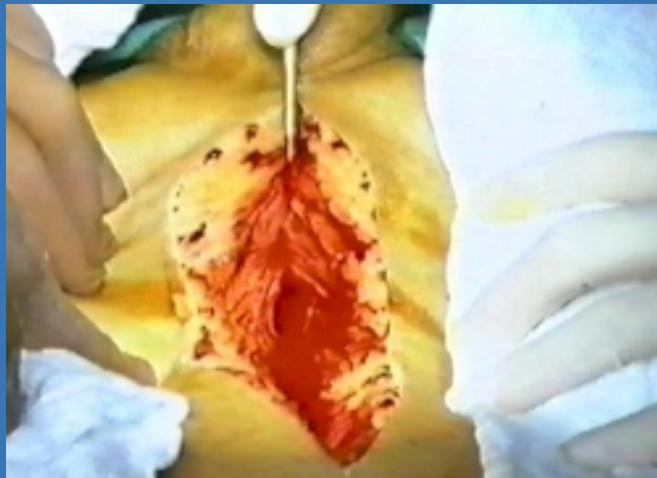
Mortality

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# The problem of early prostate cancer



*Know the type of lifestyle you live and the values that you hold dear, and make your decision based on those values."*

*- A Patient*

# Case: 65 yrs, low-risk prostate cancer

## No treatment

- 0% impotence
- 0% incontinence
- 10% death from prostate cancer

## Treatment

- 50% impotence
- 2% incontinence
- 5% death from prostate cancer



### 1 Prostate cancer patients responded less positively than patients with other cancers

	2000 %		2004 %	
	Patients with prostate cancer	Patients with other cancers	Patients with prostate cancer	Patients with other cancers
Waited more than two weeks from referral by GP to be seen by specialist	72	49	68	37
Not discussed the side effects of treatment	19	15	11	6
Not discussed how treatment had gone	14	8	13	5
Would have preferred more information about how treatment had gone	21	18	20	13
Fully understood explanation of how treatment had gone	67	76	70	81
Have a named nurse in charge of care	43	56	50	61
Home situation not taken into account when discharged from hospital	21	14	13	9
Given information about support or self-help groups	36	66	34	64
Outpatient appointment cancelled one or more times	17	13	19	11



- Decision aids for people facing health treatment or screening decisions (Cochrane Review). O'Connor AM et al. In: The Cochrane Library 2004;

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