Conflicts of interest: Dr Mortier serves as an investigator and board member for Roche. All other authors have no conflicts of interest to report.

Reprints not available from the authors.

Correspondence to: Edwina Girard, MD, Service de Dermatologie Hôpital Claude Huriez, 2 rue Michel Polonovski, 59037 Lille CEDEX, France

E-mail: edwinainesgirard@gmail.com

REFERENCES

1. Basset-Seguin N, Hauschild A, Grob J-J, et al. Vismodegib in patients with advanced basal cell carcinoma (STEVIE): a pre-planned interim analysis of an international, open-label trial. *Lancet Oncol*. 2015;16(6):729-736.
2. Sekulic A, Migden MR, Lewis K, et al. Pivotal ERIVANCE basal cell carcinoma (BCC) study: 12-month update of efficacy and safety of vismodegib in advanced BCC. *J Am Acad Dermatol*. 2015;72(6):1021-1026.e8.
3. Hallegraeff JM, van der Schans CP, de Ruiter R, de Greef MH. Stretching before sleep reduces the frequency and severity of nocturnal leg cramps in older adults: a randomised trial. *J Physiother*. 2012;58(1):17-22.
4. Miller TM, Layzer RB. Muscle cramps. *Muscle Nerve*. 2005;32(4):431-442.
5. Stroes ES, Thompson PD, Corsini A, et al. Statin-associated muscle symptoms: impact on statin therapy—European Atherosclerosis Society consensus panel statement on assessment, aetiology and management. *Eur Heart J*. 2015;36(17):1012-1022.

https://doi.org/10.1016/j.jaad.2017.11.045

The multidisciplinary tumor board for the management of cutaneous neoplasms: A national survey of academic medical centers

To the Editor: The multidisciplinary tumor board (MTB) is a meeting of various medical specialties to discuss the management of patients with cancer. In lung, esophageal, and head and neck cancers, tumor boards increase adherence to national treatment guidelines, decrease treatment delays, are educational, and instill the importance of multidisciplinary care early in training.[1-4] However, little is known about the MTB for cutaneous neoplasms. This study assesses the structure, goals, and participation patterns of the MTB in a nationwide sample of academic dermatology centers.

Over 6 weeks, 3 requests to complete an online survey (Appendix 1 available at http://www.jaad.org) were emailed to all 119 dermatology residency programs accredited by the Accreditation Counsel of Graduate Medical Education as of January 5, 2016.[5] The results are presented in Table I. Fifty of 119

Table I. Tumor board characteristics

	No.	%
Total programs with a MTB	42	84.0
Single tumor board for all skin cancers?	23	54.8
Separate tumor boards for some skin cancers?	19	45.2
Which attending physicians are present at >50% MTBs?		
Dermatologic surgery	36	85.7
General dermatology	30	71.4
Surgical oncology	39	92.9
Medical oncology	39	92.9
Radiation oncology	35	83.3
Pathology	38	90.5
Plastic surgery	11	26.19
Otolaryngology	19	45.2
Diagnostic radiology	14	33.3
Other attendees at >50% MTBs?		
Community physicians	3	7.1
Residents/fellows	37	88.1
Medical students	18	42.9
Midlevel providers	20	47.6
Ancillary staff (eg, nurse/social worker)	18	42.9
Do community physicians present patients?		
Yes	6	14.3
Are dermatology residents required to attend?		
Yes	9	21.4
Do patients attend?		
Yes	4	9.5
Can physicians at your center participate via videoconference?		
Yes	11	26.2
Can outside physicians participate via videoconference?		
Yes	3	7.1
Would you participate in a multi-institution MTB via videoconference?		
Yes	24	57.1
Is there a notification process to inform patients they were discussed at a MTB?		
Yes	23	54.8
Are the reasons for case discussion shared before the MTB?		
Yes	25	59.5
Is there a listserv of MTB participants to allow for case discussion?		
Yes	7	16.7
No, but it would be useful	33	78.6
No, and it would NOT be useful	2	4.8
When do the meetings begin?		
Before 8 AM	16	38.1
8 AM-noon	6	14.3

Continued

Table I. Cont'd

	No.	%
Noon-1 PM	8	19.1
1 PM-5 PM	6	14.3
After 5 PM	6	14.3
Frequency of MTB		
Weekly	14	33.3
Bimonthly	15	35.7
Monthly	13	31.0
Is CME offered?		
Yes	16	38.1
Percentage of cases with change in management after MTB		
1-25%	9	20.9
26-50%	20	46.5
51-75%	8	18.6
>75%	5	11.6
Percentage of melanoma in situ or stage 1A discussed in a MTB		
Never discussed	11	26.2
1-25%	26	61.9
25-50%	2	4.8
50-75%	1	2.4
>75%	1	2.4
Unsure	1	2.4
Percentage of advanced melanoma discussed in a MTB		
Never discussed	0	0
1-25%	8	19.1
25-50%	9	21.4
50-75%	10	23.8
>75%	13	31.0
Unsure	2	4.8
Percentage of high-risk squamous cell carcinoma discussed in a MTB		
Never discussed	2	4.8
1-25%	17	40.5
25-50%	7	16.7
50-75%	8	19.1
>75%	4	9.5
Unsure	4	9.5
Percentage of Merkel cell carcinoma discussed in a MTB		
Never discussed	2	4.8
1-25%	20	47.6
25-50%	2	4.8
50-75%	3	7.1
>75%	19	21.4
Unsure	6	14.3
Percentage of sarcomas/adnexal tumors discussed in a MTB		
Never discussed	3	7.1
1-25%	24	57.1
25-50%	2	4.8
50-75%	3	7.1
>75%	6	14.3
Unsure	4	9.5

CME, Continuing medical education; *MTB*, multidisciplinary tumor board.

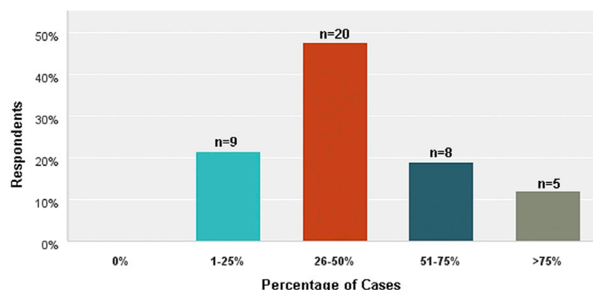

Fig 1. Respondent estimation of the percentage of skin cancer cases that have some change/addition in management after the multidisciplinary tumor board discussion.

programs (42%) completed the survey, with 42 of 50 (84%) reporting a cutaneous MTB. Nineteen programs (45.2%) have multiple distinct tumor boards, including melanoma (10), nonmelanoma of the head and neck (5), skin cancer in solid organ transplant recipients, Merkel cell, and cutaneous T-cell lymphoma. While most melanoma in situ is not discussed in a MTB, more than half of stage 1b or greater melanoma is discussed at 54.7% of programs. Less than half of high-risk squamous cell and Merkel cell carcinomas are discussed at a MTB at 62.0% and 57.2% of programs, respectively.

Regular (attendance at >50% of sessions) participants include dermatologic surgeons (85.7%), general dermatologists (71.4%), surgical oncologists (92.9%), medical oncologists (92.9%), pathologists (90.5%), and radiation oncologists (83.3%). At 4 programs, patients may attend. Only 6 programs include discussion of community physicians' patients. A minority (9/42; 21.4%) require dermatology residents to attend. At 59.5% of institutions, the reason for case discussion is shared before the meeting.

A minority (26.2%) of institutions have videoconferencing available. The majority (57.1%) would participate in a multi-institutional tumor board if it were available. Nearly all physicians agreed or strongly agreed that the MTB improves patient care (92.9%), enhances physician—physician communication (95.2%), and is educational for both trainees (95.2%) and attending physicians (100.0%). More than half of the cases presented at a MTB were felt to be managed differently after MTB discussion at 31.0% (13/42) of institutions (Fig 1).

More than 60% of MTB time is spent discussing cases for management advice at most (57.1%) programs, while 1% to 20% of time is spent presenting cases for education (71.4%), reviewing literature (64.3%), and recruiting for clinical trials (55.0%). Tumor boards last a median of 60 minutes (range, 30-90 minutes), begin most commonly before 8 AM, and are held at least once a month. Most (33/42; 78.6%) programs lack, but would like a listserv of tumor

Download English Version:

https://daneshyari.com/en/article/8715032

Download Persian Version:

https://daneshyari.com/article/8715032

Daneshyari.com