



Review

Evaluation of the benefit and use of multidisciplinary teams in the treatment of head and neck cancer



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SUMMARY

Given the complexities of multimodality treatment for patients with head and neck cancer, the rationale for the use of multidisciplinary teams (MDTs) to define individual optimal treatment strategies on a per-patient basis is apparent. Increased use of guideline-directed approaches, reduced time to treatment and improved outcomes, which result from use of an MDT approach in head and neck cancer, have been documented. A discussion of these recent advances, as well as presentation of available country-specific guidance on the roles and responsibilities of team members, supports the creation of similar local-language recommendations for the treatment of patients with head and neck cancer. Finally, expert practical advice on the implementation of MDTs may enable the establishment of the MDT approach more universally around the world.

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Introduction

Given the complexities of multimodality treatment for patients with cancer, no one medical professional can possess the necessary background to make optimal treatment decisions independently or avoid inevitable unconscious bias toward their own area of expertise. In most major cancer types, multidisciplinary teams (MDTs) were implemented previously, and, in recent years, the MDT approach has been extended to head and neck cancer. Head and neck cancers involve several anatomically diverse sites, including larynx, pharynx, nasal cavity, paranasal sinuses, and oral cavity. Both the cancer and its treatment can affect vital functions, such as breathing and swallowing, be associated with poor functional outcome (e.g. chewing and speech), and have profound effects on cosmetic appearance, all of which may affect the patient's quality of life. The complexity of disease, the need for multimodality

treatment, which can include surgery, radiation, chemotherapy, and/or targeted therapy, and the patient population, which is more likely to be elderly and have comorbidities and less social support, argue for an individually tailored treatment plan. Furthermore, treatment goals—which include cure, organ preservation, palliation, and a desire to minimize toxicity, reduce symptoms, and maintain quality of life—must also be considered. Thus, optimal management of patients with head and neck cancer should involve a range of healthcare professionals with relevant expertise [1]. This review discusses the data supporting the use of MDTs for the treatment of patients with head and neck cancer and presents the available country-specific guidance to enable more widespread implementation of MDTs to improve the care of patients globally.

Methods

A literature search of PubMed and Google Scholar, with the combined search terms of “head and neck cancer” and “multi-disciplinary” for the period January 1, 2000, to November 1, 2015, was performed. In addition, the websites of prominent national and international organizations that develop English-language

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cancer guidelines—Cancer Care Ontario, the European Society for Medical Oncology (ESMO), the National Comprehensive Cancer Network (NCCN), the New Zealand Guidelines Group, the Sociedad Española de Oncología Médica (SEOM), and the UK National Institute for Health and Clinical Excellence—were searched.

Guidelines and legal requirements are difficult to identify and access, and we recognized that such guidelines would be written in the local language. Therefore, we contacted Merck colleagues with specific knowledge of head and neck cancer treatment in their respective countries to request additional information regarding the legal requirements for MDTs, the availability of guidelines, and key supporting references for each country. Responses were received from 29 countries.

Rationale for the MDT approach

In the absence of an MDT discussion, there is a real risk that factors relevant to treatment planning might be missed, and, in some cases, patients may not be considered for the appropriate treatment. Thus, the ability to individualize the optimal treatment approach for each patient may be lost. In addition, the opportunity to recruit to important clinical trials may be missed. As treatment in head and neck cancer began to include a multimodality approach, the benefits of MDTs in decision-making became apparent [2]. Several governing bodies—including ESMO [3], the NCCN [4], and SEOM [5]—recommend that treatment plans be established by an MDT [6,7]. Similarly, a working group of Asian experts

Table 1
Recommended team composition.

Team ^a	Specialty	Supported by guidelines and published references in countries
Core team	Head and neck surgeon(s)/oral and maxillofacial surgeon(s)	AU, CA, DE, DK, IT, NL, NZ, UK
	Radiation oncologist	AU, CA, DE, IT, NL, NZ, UK
	Medical oncologist	AU, CA, DE, DK, IT, NL, NZ, UK
	Pathologist	AU, CA, DE, DK, NL (as extended team), NZ, UK
	Radiologist ± PET-trained imaging specialist/diagnostic radiologist/nuclear medicine specialist with PET expertise	AU, CA, DE, DK, NZ, UK
	Otolaryngologist	IT, NZ
	Dentist/oral health consultant	AU, CA, IT, NZ, UK
	Maxillofacial prosthodontist	CA, NZ
	Plastic and reconstructive surgeon	AU, CA, DK (as extended team), NL, NZ, UK
	Referring physician	NZ, UK
	Hematologist	DE
	Respiratory physician	AU
	Palliative medicine physician	AU, UK
	Specialist nurse	AU, CA, DK, IT, NZ, UK
	Speech language pathologist	CA, IT, NL (as extended team), NZ, UK
	Dietitian	CA, IT, NL (as extended team), NZ, UK
	Social worker	AU, CA, IT, UK (as extended team)
	Clinical trial coordinator	AU
	Data manager	AU, UK
	MDT meeting coordinator/pathway project officer/administrative officer/care coordinator	AU, DK, NZ, UK
Extended team	Neurosurgeon	AU, CA, DK
	Upper GI surgeon	AU
	Thoracic surgeon	CA
	Prosthetic anaplastologist	CA, NL
	Vascular surgeon	AU
	Anesthesiologist	CA, UK
	Gastroenterologist	UK
	Endocrinologist	DK
	Interventional radiologist	CA
	Neurotologist	CA
	Neurosurgeon	NZ
	Ophthalmologist	AU, CA, DK, UK
	Psychiatrist/mental health professional	AU, CA, IT, NZ, UK
	Critical care physician	CA
	Radiation physicist	CA, NL
	Radiation therapist/therapeutic radiographer	CA, NL, UK
	Hyperbaric medicine	CA
	Dermatologist	CA
	Pain management specialist	AU, CA, IT, NZ, UK
	Pharmacist	CA
	Addiction services	AU
	Audiology	AU
	HCP with expertise in gastrostomy placement	CA, NZ, UK
	Palliative care	CA, NZ
	Dental hygienists/technician	CA, NL, UK
	Geriatric cancer assessment team	AU
	Adolescent and young adult cancer assessment team	AU, NZ
	Home care team	CA
	Physiotherapist	CA, NL, UK
	Occupational therapist	AU, CA, UK
Rural/remote liaison nurse	AU	
Benefits advisor	UK	

AU, Australia; CA, Canada; DE, Germany; DK, Denmark; IT, Italy; MDT, multidisciplinary team; NL, the Netherlands; NZ, New Zealand; PET, positron emission tomography; UK, United Kingdom.

^a IT and NZ guidelines do not distinguish between a core team and extended team. France is not included in the table because the French guidelines do not delineate the specific specialists that must be included in the MDT.

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