



Original article

Effects of a regional guideline for completion axillary lymph node dissection in women with breast cancer to reduce variation in surgical practice: A qualitative study of physicians' views



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ABSTRACT

Background: Recently the impact of completion axillary lymph node dissection (cALND) after positive sentinel lymph node biopsy on significant outcomes has been questioned, leading to variation in surgical practice. To address this variation, a multidisciplinary working group created a regional guideline for cALND. We explored the views and experiences of surgeons, medical oncologists (MOs), radiation oncologists (ROs) in a qualitative study that examined guideline implementation in practice.

Methods: The Pathman framework (awareness, agreement, adoption and adherence) informed the interview guide design and analysis. Semi-structured interviews were conducted with MOs, ROs and surgeons and transcribed. Transcripts were coded independently by 2 members of the study team and analyzed. Disagreements were resolved through consensus.

Results: Twenty-eight physicians (5 MO; 6RO; 17S) of 41 (68% of those approached) were interviewed. Ten of 11 (91%) hospital sites (54% community; 46% academic) and all 4 cancer clinics within the region were represented. Twenty-seven physicians (96%) were aware of the guideline, with all physicians reporting agreement and general adherence to the guideline. Most physicians indicated nodal factors, age and patient preference were key components of cALND decision-making. Physicians from all disciplines perceived that the guideline helped reduce variation in practice across the region. There were concerns that the guideline could be applied rigidly and not permit individual decision-making.

Conclusions: Physicians identified breast cancer as an increasingly complex and multidisciplinary issue. Facilitators to guideline implementation included perceived flexibility and buy-in from all disciplines, while individual patient factors and controversial supporting evidence may hinder its implementation.

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Background

The results of the American College of Surgeons Oncology Group (ACOSOG) Z0011 randomized controlled trial have called into

question the practice of routine completion axillary lymph node dissection (cALND) after 1–2 positive sentinel lymph nodes. The Z0011 trial enrolled patients with T1 or T2, clinically node negative breast cancer treated with lumpectomy, sentinel lymph node biopsy (SLNB) and whole-breast irradiation. Patients with 1 or 2 hematoxylin and eosin (H&E)-positive SLNs were randomized to cALND or SLNB alone. At a median follow-up of 6.3 years, no significant differences were found between the 2 groups in the rates of axillary recurrence (0.5% vs 0.9%), local recurrence (3.6% vs 1.9%) or

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Abbreviations

ASBrS	American Society of Breast Surgeons
ACOSOG	American College of Surgeons Oncology Group
cALND	Completion axillary lymph node dissection
H&E	Hematoxylin and eosin
LHIN4	Local health integration network
MCCs	multidisciplinary case conferences
MO	medical oncologist
RO	radiation oncologist
S	surgeon
SLNB	Sentinel lymph node biopsy
+SLNB	Positive sentinel lymph node biopsy

overall and disease-free survival (91.9% vs 92.5% and 82.2% vs 83.8% respectively) [1,2]. The Z0011 trial results suggest that cALND may be omitted in selected patients with 1 or 2 positive sentinel lymph nodes, including those with macrometastases [1,2]. Yet, several study limitations have caused concern about applying trial results to clinical practice [3–5].

Following the publication of Z0011, several large institutions (e.g., MD Anderson, Memorial Sloan-Kettering) implemented its findings into their clinical practice [5–8] while other groups designed algorithms to predict non-SLN metastasis to help with cALND decision-making [9,10]. At that time, no accepted guideline of how to apply Z0011 results to clinical practice existed, although the American Society of Breast Surgeon (ASBrS) had drafted a Position Statement [11]. In a 2011 survey of ASBrS members, 97% reported they were familiar with Z0011 and 57% reported that they would infrequently or never perform cALND in women who met Z0011 eligibility criteria [12]. They also found that 36% would consider omission of cALND in patients planned to receive accelerated partial breast irradiation and 27% would consider omission of cALND in patients not planned to receive radiation. These latter results are concerning as these two scenarios fall outside Z0011 eligibility criteria [12]. In summary, there is absence of consensus in management of the axilla in patients with a positive (+)SLNB. This lack of consensus is unlikely to be resolved until evidence from ongoing trials becomes available and may lead to further variation in surgical practice, and potentially will make decision-making by surgeons and patients with positive SLNs increasingly difficult.

To address the lack of consensus for cALND in our health region after the publication of Z0011, a Multidisciplinary Working Group comprised of community and academic surgeons, radiation oncologists, medical oncologists and pathologists developed an evidence-based guideline in 2011/2012 (Table 1). The guideline was based upon the results of Z0011, a literature review, and recommendations from the Working Group and was disseminated to clinicians in 2012. The American Society of Clinical Oncology and the National Comprehensive Cancer Network have since updated their current practice guidelines to address the issue of cALND following +SLNB [13,14].

To assess the physicians' experiences with the regional guideline and the effect of the guideline on practice, we conducted a mixed-method study with quantitative (reported separately) [15] and qualitative components; this paper describes the results of the qualitative component of physicians' views. The objectives of this study were to: 1) assess the acceptance and self-reported experience with the cALND guideline by surgeons, radiation oncologists and medical oncologists; and 2) identify issues related to adoption of the guideline.

Methods

Interviews were conducted between January and November 2014 with physicians in Local Health Integration Network 4 (LHIN4) in Ontario. This region serves 1.4 million people with 11 hospitals and four regional cancer centre/clinics. Research Ethics Board approval was obtained. Since 2005, surgeons in LHIN4 have participated in quality improvement activities in breast cancer (The Quality Initiative in Breast Cancer Surgery in LHIN4 project) [16] where surgeons chose quality indicators and received peer comparison feedback at annual workshops. The Multidisciplinary Working Group was developed in 2011 and met 3 times to review evidence and develop the guideline. Consensus from all members was obtained on the final version of the guideline (Table 1). The guideline was mailed to all surgeons, medical oncologists and radiation oncologists in LHIN4 in August 2012 and again in April 2013, and was also reviewed and discussed at a LHIN4 workshop in May 2013.

We used the Pathman model [17] to guide the interviews and analysis. This model identified four steps in the uptake of guidelines by physicians: 1) awareness; 2) agreement; 3) adoption into practice; 4) adherence in usual practice. We also asked physicians about potential barriers and facilitators to changing their practice [18–20].

Data collection

An interview guide was pilot-tested for clarity, comprehensiveness, and length with two physicians and revised. Semi-structured face-to-face interviews were conducted by MT with surgeons, radiation oncologists and medical oncologists, recorded verbatim and transcribed.

Recruitment

One or two physicians (surgeons, medical oncologists (MOs), radiation oncologists (ROs)) from each hospital/cancer clinic with representation from academic and community centre were recruited. We included physicians who had participated in the development of the guideline and those who had not. To guide the number of physicians recruited, we used the principle of data saturation which occurs when identified themes begin to recur and no new themes emerge from the analysis [21]. This occurred after 28 interviews.

Coding and analysis

A coding guide was created from the Pathman model [17]. Two researchers (SDC and MC or MAO) coded each interview transcript independently; disagreements were resolved by consensus. Interview data pertaining to physicians' views of guideline agreement, adoption, and adherence were analyzed descriptively. The rest of the transcripts were analyzed with the constant comparative method whereby codes were compared within and across transcripts [22]. Qualitative analytic techniques were used to identify the main themes in the transcribed data [22–24]. Themes were reviewed with a fourth team member (PJM). We used a systematic and transparent approach for data collection and analysis which included creating and maintaining an audit trail of coded transcripts, interview notes and memos and periodic meetings of core team members.

Results

Twenty-eight (68%) of 41 physicians participated (5 MOs, 6 ROs and 17 surgeons). Ten of 11 (91%) hospital sites and all 4 cancer

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