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Original Research Article

Helping patients make informed decisions. Two-year evaluation of the Gustave Roussy prostate cancer multidisciplinary clinic

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ABSTRACT

Objectives: The initial treatment decision for newly diagnosed non-metastatic prostate cancer is complex. Multiple valid approaches exist, without a clear and absolute consensus for every clinical scenario, and therefore specialist opinions may vary. Multidisciplinary consultations focusing on shared decision-making aim to provide an apposite tool for the initial treatment decision. We have evaluated the first two years of activity of the Gustave Roussy Prostate Cancer Multidisciplinary Clinic (PCMC), dedicated to the initial decision-making for non-metastatic prostate cancer.

Methods: PCMC consists of two consecutive specialist consultations with a urological surgeon and a radiation oncologist, followed by a dedicated Tumor Board discussion. A study questionnaire was addressed to all PCMC patients via postal mail. Medical notes and questionnaire responses of 195 eligible patients were analyzed.

Results: The questionnaire response rate was 69% (134 patients). Complete satisfaction rate was high (114 of 118 responders, 97%). Patients were offered new treatment options in 55% of cases, and felt better informed in 98% (122 of 125 responders). The double consultation was considered useful (124 of 129 responders, 96%). Reported feeling of active participation was significantly elevated (117 of 131 responders, 89%), while 46% of patients (57 of 125) modified their decision on the management of their prostate cancer following their PCMC consultation.

Conclusions: The experience of a multidisciplinary consultation in the initial management of non-metastatic prostate cancer renders high patient satisfaction, improves their appreciation of feeling better informed, promotes active participation and shared decision-making and strongly influences their final decision.

Introduction

The complexity of treatment strategies pertaining to non-metastatic prostate cancer (CaP) is well recognized, necessitating a co-operation between specialist colleagues, but also a significant input from the patients themselves [1]. The dramatic changes in incidence, diagnostic stage and mortality in the last 30 years resulted in modification of medical attitudes and development of a variety of management options (surgery, external-beam radiotherapy, brachytherapy, cryotherapy, high-intensity focused ultrasound, hormonal therapy, active surveillance, watchful waiting). For localized CaP there does not exist a clearly established, universally applied advantage of a given treatment modality over the others; treatment decision is an intricate process that ought to include risk assessment and precise disease extent and topography, amongst other factors.

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A need for multidisciplinary involvement and shared decision-making therefore evolved, highlighting the cardinal importance of patient education.

The Gustave Roussy Prostate Cancer Multidisciplinary Clinic (PCMC), inaugurated in March 2011, is a comprehensive weekly clinic for localized or locally advanced CaP patients requesting a second opinion, based on the model of shared decision-making. It offers expert specialist care in a collaboration between Gustave Roussy and the urological surgical teams of the Hôpital Bicêtre and Hôpital Saint Joseph, Paris, France. Access to the PCMC is via general practitioner or specialist referral, or at the patient's own initiative.

This specialist clinic offers patients the opportunity to successively consult with a radiation oncologist and a urological surgeon, part of a dedicated 5-member team. Consultation time for each specialist is 45 min. All cases are discussed at the Genitourinary (GU) Tumor Board on the same day, with the further participation of medical oncologists, specialist and interventional radiologists and histopathologists. The final treatment plan is established at this multidisciplinary meeting. Patients were informed of the Tumor Board recommendation during a follow-up clinic or telephone consultation.

We consider the concept and design of this PCMC to be adapted to the specific setting of localized and locally advanced CaP. We present here an evaluation of the first two years of the Gustave Roussy PCMC activity.

Methods

Patient cohort

All patients seen in the PCMC clinic were included in the initial register; the following exclusion criteria were applied for the final cohort analysis, aiming for bias elimination:

- Absence of histopathological confirmation of prostatic adenocarcinoma.
- Pre-treated patients.
- Patients not specifically addressed to the PCMC Clinic, seen by a single specialist in regard with a previously established treatment plan.
- Patients belonging to Gustave Roussy staff.

Data collection

The data source was the hospital electronic and paper records and a dedicated questionnaire. Data were collected in a dedicated Excel-based database (Microsoft Inc, Washington, USA). Table 1 presents an outline of the recorded data. The patient socioeconomic status was scored according to the French 2003 classification of Professions and Socio-Professional Categories [2]. All PSA measurements and biopsies were performed outside Gustave Roussy prior to the consultation date. The weight and volume of the prostatic gland were estimated based on MRI, CT, ultrasound imaging and clinical examination. The T.N.M. classification was according to the 7th AJCC edition [3]. The clinical T stage was scored based on the information in the medical notes; since the precise T2 stage scoring was available for only a small subset of patients, it was not included in the analysis. Apical involvement and capsular and seminal vesicle involvement were scored based on available information (clinical examination, imaging, localization of positive cores).

This study was designed as an early service evaluation, and therefore of a short follow-up, so no long-term data on oncologic outcome could be retrieved.

Table 1
Collected data/analysis variables.

Personal data	Marital status
	Socio-economic status
Consultation details	Consultation year
	Initial/s opinion consultation
	Consultation order (surgery/ radiotherapy)
	Consulting urologist
	Consulting radiotherapist
Comorbidities	Cardiovascular disease
	Previous TURP
	Family history of prostate cancer
LUTS/sexual dysfunction	IPSS score
	Presence of nocturia
	Presence of hesitancy
	Presence of terminal dribbling
	Presence/quality of erection
PSA	PSA value
Prostate biopsy: core number	Total number of cores
	Total number of positive cores
	Number of positive cores in the right lobe
	Number of positive cores in the left lobe
Prostate biopsy: length	Total length of biopsy cores
	Total length of tumour
	Total length of tumour in the right lobe
	Total length of tumour in the left lobe
Gleason score	Total Gleason score
	Primary grade of Gleason score
	Secondary grade of Gleason score
Prostate Weight/Volume	Estimated weight & volume of the prostate gland
TNM classification	Clinical T stage
Imaging	MRI performed
	Local extension on MRI
	Pathological lymph nodes on MRI
	CT scan performed
	Pathological lymph nodes on CT
	Bone scan performed
	Findings indicative of metastasis
Multimodal staging (clinical, biopsy, imaging)	Apical involvement
	Capsular infiltration
	Seminal vesicle infiltration
Prognostic stage	NCCN stage
	D'Amico classification
Proposed treatment plans	Pre-existing treatment plan (if applicable)
	Consultant urologist proposal
	Consultant radiotherapist proposal
	Multidisciplinary team proposal
Patient choice	Chosen treatment modality
	Modification of pre-existing choice
	Place of treatment
	Modification of place of treatment

Questionnaire

The project questionnaire was designed and dispatched via postal mail at two time-points at a 5-month interval, accompanied by an introductory letter and prepaid postage envelope, in accordance with national legislations. The questionnaire enquired upon patient satisfaction, perception of the consultation experience, and aimed to collect complementary information on CaP management after the time of PCMC consultation (Table S1).

Statistical analysis

The reported percentages in the descriptive statistics are estimated on the total number of the cohort (n = 195). The reported percentages relevant to questionnaire responses refer to the total number of received responses, unless otherwise specified. The percentage values were rounded to the nearest unit.