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To cite this article: Anusheel Munshi & Manju Sengar (2011) Multidisciplinary care in oncology: Are we united?, Acta Oncologica, 50:2, 314-316, DOI: [10.3109/0284186X.2010.519347](https://doi.org/10.3109/0284186X.2010.519347)

To link to this article: <https://doi.org/10.3109/0284186X.2010.519347>



Published online: 19 Sep 2010.



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LETTER TO THE EDITOR

Multidisciplinary care in oncology: Are we united?

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The foundation of modern oncology care lies in the simple albeit meticulous observations made by our forefathers. Their efforts to document the natural history of disease and its alteration by thoughtful interventions evolved into present day understanding of cancer and its treatment. A simple observation by Beatson that removal of ovaries leads to tumour regression in patients with metastatic breast cancer paved the way for present day evidence based hormonal therapy of breast cancer [1]. The humble era of observations and interventions in individual patients slowly and steadily evolved into the present day mercurial age of evidence based medicine.

Evidence based medicine has its summary mantra in two effusively adored terms by its proponents and purists: “randomised controlled trials” and “metaanalysis”. In a large majority of cancers, evidence based medicine calls for a multidisciplinary approach to decide the best available and customised treatment for a patient who walks into the clinic. An ideal world would have the three prime modalities of cancer treatment, i.e. the radiation, medical and surgical oncologists work in remarkable harmony and unison to achieve the perfect remedy for patients in terms of cure or palliation, as the case may be. However, in the real practice, prejudices and biases often punctuate patients care in oncology set-ups.

“Evidence based medicine has to be practiced” – is the notion well observed and oft quoted in joint clinics, and “areas of controversy should be answered by phase III randomised trials” is a statement that brings agreeable nods. However, this seemingly perfect world ends once oncologists step out of the joint clinic door. In their one to one dealing with patients, evidence often gets sidelined or is at best interpreted in a “clinician compatible” format. The power of stature, authority and seniority often overshadows the

humility and ethics of classical multidisciplinary evidence based medicine, bending the latter backwards to pave way for vehemence based medicine, eminence based medicine, gut feeling based medicine and medicine without nerves [2]. Worse still, in confines of their consulting rooms, the feeling and leaning for their speciality overrules rational multidisciplinary evidence (Table I).

Often oncologists love to interpret results of trials in a way that suits them best. A case in point is a very recent randomised study proving the equivalence of chemo-radiation to chemo-radiation followed by surgery in locally advanced lung cancer [3]. This study is sure to get the radiation oncologists grinning and set their surgical colleagues hunting for the “lacunae and pitfalls” in the study design. In a similar vein, the following could be specialists’ reactions to a recent SEER data article concluding that radical hysterectomy is superior to primary radiation in women with cervical cancer lesions of < 6 cm [4]. The surgical oncology colleagues would promptly emphasise the Kaplan Meier survival curves displaying the difference in the two arms, emphasising the term – “recent SEER data...”. A radiation oncologist would have this to say:

“The study is NOT a comparison of radical hysterectomy alone versus radiation. When nearly 50% of the operated patients needed adjuvant radiotherapy, the use of “radical hysterectomy” or “surgery” is misleading. This study exposes the limitations of doing retrospective analyses. There is absolutely no mention in results or discussion about the complications, side effects or quality of life in either group. Rectal and bladder toxicities which are likely to be more in the surgery arm in view of use of dual modality have not been reported. In view of above reasons, this

Table I. What we say!

Category	Surgical oncologist	Radiation oncologist	Medical oncologist
pCR rates	All our patients achieve a pCR after surgery	No rational talk of pCR is possible without RT	Chemotherapy is by its own capable of producing pCR
Speed	A quick, no nonsense modality	Takes time but effective	Yes, takes time but often delivers
Organ preservation	Have heard of this	No organ preservation can be contemplated without radiation (with a bit of help from Medical Oncology)	Chemotherapy is a must with radiation
Palliation	What is this?	We have a very effective modality	Drugs are useful in quite a few cases
Usefulness in compromised patients	No comments	An effective and time tested modality	Yes, but in selected cases
Who is the actual oncologist	Original oncologists	First true oncologists	Real oncologists
Modality action	Local – the tumour is out!	Local – all the local cells are killed!	Reaches every nook and corner of the body!
Preciseness of treatment	Treat what we see!	Only modality that can vary intensity according to concentration of tumour cell (IMRT et al.)	Blanket treatment with targeted capabilities!

paper needs to be read with multiple and repeated pinches of salt.”

To quote another example for the same issue, all of us are aware of the very different perspectives of surgical, medical and radiation oncologists’ on the PORT lung cancer metaanalysis [5].

Treatment course of a patient could also be heavily influenced by where the patient is seen first in the hospital. This may be aptly termed “First sight-first Right” rule. What this means is that who the patient meets first in the oncology care can have a strong bearing on his treatment course. As a result of this seemingly inconsequential and innocuous step of a patient with early carcinoma prostate in the hospital corridors, he could either land up with a prostatectomy (now nerve sparing) or radical radiotherapy (now intensity modulated radiotherapy or image guided radiotherapy or proton therapy).

Another scenario with the potential of making oncologists pick bones is a patient presenting with side effects of therapy. The dominant motto is “pass the buck”. Radiation oncologists are perennially wary of data of secondary malignancies after radiotherapy, often taking some solace from studies implicating chemotherapy in causation of second cancers and are quick to point secondary cancers in surgery alone series! For the medical and surgical oncologists, a fall in white cell count after chemotherapy (irrespective of any field size or site in the bony skeleton) is compounded by radiotherapy. Similarly all chemotherapy is potentially toxic for the die hard radiation colleagues. Cardiac effects after radiotherapy and chemotherapy in breast cancer incite an

endless blame game between medical and radiation oncologists. For the medical oncologists, newer drugs (liposomal doxorubicin, protective agents) have made modern chemotherapy largely cardiac safe. For the radiation oncologist, cardiac morbidity is “on the decline as shown by recent SEER data” due to “modern machines and precise treatment” [6]. Another classical example of the abovementioned idiom is cosmetic outcome in breast conservation [7]. A good cosmetic outcome in breast cancer has many speciality fathers – a bad one is a perennial orphan. The responses from individual specialities are typical (surgical oncologist – she unfortunately has bad post radiation fibrosis, Radiation oncologist – Nothing can reverse a bad surgical cosmesis, Medical oncologist – anyways chemotherapy has a minimal effect on cosmesis).

Often the statistical jargon comes handy for the oncologists in impressing upon respective treatment benefits. Clinical trials addressing the similar questions are often designed with different endpoints and leave the question only partly answered. It gives enough opportunity to the end-users to interpret the data in their own way. The non-uniformity of reporting in various journal and trials has substantially augured this cause. This has also been made necessary by the relative inability of all specialities in making a visible difference in overall survival outcomes, the single most important endpoint. The outcome measures in vogue therefore are disease free survival, progression free survival, clinical benefit rate and quality of life. No doubt these too are important in specific oncological situations. Medical oncologist prefer, a statement of 17% relative risk reduction in disease free survival (DFS) than stating that the same

treatment produces an absolute 2% DFS increase [8]. Similarly, saying that “giving a radiotherapy boost to the tumour bed after breast conservation causes 40% reduction in local recurrence rates” sounds more ground breaking to the radiation oncologist rather than talking about a small 4% across the board absolute difference in local control rates with use of additional boost [9].

Each of the primary specialities can boast of “phenomenal and revolutionary” progress in the past few years. A modern day radiation oncologist would love to talk about the milestones and strides his discipline has taken in recent past. This would range from “establishment” of IMRT to the emergence of proton therapy to image guided radiotherapy (IGRT) to arc therapy, and the list would go on [10,11]. Surgeons, while lagging in absolute technical advancements, would catch up by talking about newer buzz techniques. Sentinel lymph node dissection, oncoplasty, video assisted and minimal invasive surgery would be some examples of these [12]. Targeted therapies or magic bullets are the buzz words for medical oncologists [13]. For all the above “modern” techniques and treatments, the real benefits and especially talks about difference in absolute survival are met with hushed whispers.

To summarise, oncologists, too are humans, filled (as their patients!) with myriad of emotions. While all oncologists want their patients to get well, most of them would not mind getting some credit, big or small for their work and a few accolades for their speciality on the way. The hallmark for maturity, nevertheless, would be to understand and comprehend one’s own speciality from a neutral perspective. More importantly, we need to realise the right and might of the specialists on the other side of the fence. “Catching them young” could orient budding oncologists for a mature comprehensive outlook in oncology care.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

- [1] Beatson G. On the treatment of inoperable cases of carcinoma of the mamma: Suggestions for a new method of treatment with illustrative cases. *Lancet* 1896;2:104–7.
- [2] Isaacs D, Fitzgerald D. Seven alternatives to evidence based medicine. *BMJ* 1999;319:1618.
- [3] Albain KS, Swann RS, Rusch VW, Turrisi AT 3rd, Shepherd FA, Smith C, et al. Radiotherapy plus chemotherapy with or without surgical resection for stage III non-small-cell lung cancer: A phase III randomised controlled trial. *Lancet* 2009;374:379–86.
- [4] Bansal N, Herzog TJ, Shaw RE, Burke WM, Deutsch I, Wright JD. Primary therapy for early-stage cervical cancer: Radical hysterectomy vs radiation. *Am J Obstet Gynecol* 2009;201:485e1–9.
- [5] Postoperative radiotherapy in non-small-cell lung cancer: Systematic review and meta-analysis of individual patient data from nine randomised controlled trials. PORT Meta-analysis Trialists Group. *Lancet* 1998;352:257–63.
- [6] Munshi A. Breast cancer radiotherapy and cardiac risk: The 15-year paradox! *J Cancer Res Ther* 2007;3:190–2.
- [7] Munshi A, Kakkar S, Bhutani R, Jalali R, Budrukkar A, Dinshaw KA. Factors influencing cosmetic outcome in breast conservation. *Clin Oncol (R Coll Radiol)* 2009;2:285–93.
- [8] Howell A, Cuzick J, Baum M, Buzdar A, Dowsett M, Forbes JF. Results of the ATAC (Arimidex, Tamoxifen, Alone or in Combination) trial after completion of 5 years’ adjuvant treatment for breast cancer; ATAC Trialists’ Group. *Lancet* 2005;365:60–2.
- [9] Bartelink H, Horiot JC, Poortmans PM, Struikmans H, Van den Bogaert W, Fourquet A. Impact of a higher radiation dose on local control and survival in breast-conserving therapy of early breast cancer: 10-year results of the randomized boost versus no boost EORTC 22881–10882 trial. *J Clin Oncol* 2007;25:3259–65.
- [10] Johansen S, Cozzi L, Olsen DR. A planning comparison of dose patterns in organs at risk and predicted risk for radiation induced malignancy in the contralateral breast following radiation therapy of primary breast using conventional, IMRT and volumetric modulated arc treatment techniques. *Acta Oncol* 2009;48:495–503.
- [11] Søndergaard J, Hoyer M, Petersen JB, Wright P, Grau C, Muren LP. The normal tissue sparing obtained with simultaneous treatment of pelvic lymph nodes and bladder using intensity-modulated radiotherapy. *Acta Oncol* 2009;48:238–44.
- [12] Veronesi U, Viale G, Paganelli G, Zurrada S, Luini A, Galimberti V. Sentinel lymph node biopsy in breast cancer: Ten-year results of a randomized controlled study. *Ann Surg* 2010;251:595–600.
- [13] Lam KC, Mok TS. Targeted therapy: An evolving world of lung cancer. *Respirology* 2010. [Epub ahead of print].