



FEATURE STORY

Meetings of the Minds

BY CHARLOTTE HUFF

What is multidisciplinary care, and where can patients get it?

Clay Dale hadn't heard anything about a treatment concept called multidisciplinary care. All he knew was that time mattered—his rectal tumor was classified as stage 2A and had already reached the outer wall of his colon. And he wanted as many specialists as possible to scrutinize his case.

As Dale and his wife, Meg, made phone calls and researched medical facilities, they didn't always encounter the same sense of urgency until they reached Hollings Cancer Center, located at the Medical University of South Carolina. "They were so aggressive about saying, 'Let's get you in here and let's get treatment started,'" Dale recalls. "Some of the other places we talked to said, 'We can get you in in a couple of months.'"

So the 29-year-old North Carolina man, who helps run a family forestry business and lives in a rural community near the Tennessee border, packed up his family of four and drove six hours to the Charleston-based facility.

Since last September, Dale has completed a battery of treatments recommended by the center's multidisciplinary gastrointestinal team, including chemotherapy and radiation to shrink the tumor before surgery and additional chemotherapy afterward.

Multidisciplinary care, a rather cumbersome term, simply refers to close coordination among a cross-section of cancer specialists and other clinicians, both in designing an initial treatment plan and throughout the process. It's hardly a new concept, dating back decades for some malignancies, such as leukemia and childhood cancers. But the approach has become increasingly entrenched, at least in academic medical settings, as the treatment of cancer has become more complex and patients are more savvy about the sometimes dizzying array of options.

Providing multidisciplinary treatment, though, does require a significant level of resources, including staff and time, potentially placing it out of reach for rarer malignancies or community oncology practices, according to physicians interviewed. But patients can adopt a number of approaches to broaden their access to multi-faceted expertise, most importantly at the time of diagnosis, even if they don't have easy access to a multidisciplinary program.



Clay Dale, with his wife, Meg, and their children, received

multidisciplinary care to treat his rectal tumor. Photo by Matt Rose.

Teaching hospitals benefit from a phalanx of physicians in training and specialists who are perhaps only a few floors away with specialized diagnostic and therapeutic capabilities. Thus, they frequently feature a full house of multidisciplinary programs. The Hollings website, for example, lists 10 such teams. Cancer specialists working in private practice can be more scattered and may, to varying degrees, have competing interests or their own referral patterns, says Ralph Boccia, MD, a community oncologist at the Center for Cancer and Blood Disorders in Bethesda, Maryland. “As long as we are independent practitioners who practice in disparate geographies within the same community, these are efforts that are difficult to organize,” he says.

As a result, adult access to multidisciplinary treatment is relatively new and the quality can vary significantly compared with children’s cancer care, says Joseph Simone, MD, director of the University of Florida Shands Cancer Center, who spent nearly three decades earlier in his career at St. Jude Children’s Research Hospital in Memphis, Tennessee. Depending upon the program involved, the multidisciplinary care can be non-existent to “something very sophisticated,” he says of today’s efforts for adults.

An Emerging Focus

Pediatric cancer specialists were among the first to embrace a multidisciplinary concept, in some cases as far back as the 1960s, Simone says. Since relatively few children develop -cancer compared with adults, their care is already centralized at academic medical centers or children’s hospitals and the treating physicians are frequently employed by those institutions, he says. “So it was much easier to organize the [multidisciplinary] care under those circumstances,” says Simone, also a former chairman of the National Comprehensive Cancer Network.

On the adult side, breast cancer was among the first malignancies to be treated by multidisciplinary teams, in part because of a growing awareness in the ’80s of the complex timing and treatment options involved, says Joan McClure, senior vice president of clinical information and publications at NCCN. Also, breast cancer has gotten a lot of public attention because of its active advocacy community, she says.

Specifics can vary somewhat, but a tumor board remains a core component of multidisciplinary programs, with a cross-section of physicians and other clinicians gathering to review a patient’s imaging scans, pathology, medical history, and other records. Another common fixture is some type of navigator, frequently a nurse, to help collect the relevant data prior to the meeting and then assist patients as they literally navigate the system to obtain the recommended care.

Gathering cancer specialists together can foster debate, facilitate continuing education, and sometimes alter treatment recommendations. One study, published in 2006 in the journal *Cancer*, analyzed the results of 149 breast cancer patients referred to the University of Michigan’s multidisciplinary breast

cancer clinic for a second opinion. Half of the patients—52 percent—got a different surgical recommendation after their case was reviewed by specialists.

In some cases, additional biopsies were recommended, says Michael Sabel, MD, one of the researchers and associate professor of surgery at the University of Michigan Medical School. In others, specific surgical techniques were suggested, such as a sentinel lymph node biopsy, that could improve the patient's quality of life, he says.

The team approach is particularly well suited for malignancies in which there are a number of timing-related decisions, such as whether to administer chemotherapy or radiation prior to surgery, cancer specialists say. Head and neck malignancies are one frequently provided example. So is rectal cancer.

Once Dale arrived at Hollings Cancer Center, he met with the medical oncologist, the surgeon, and other key specialists within short order. By late spring, Dale's case had been discussed by the tumor board at least three times, including before and after rectal surgery, according to Dale's oncologist, Melanie Thomas, MD, associate director of clinical investigations at Hollings.

The pre-surgical chemotherapy and radiation—five weeks and six weeks, respectively—did shrink the tumor until it was classified as stage 1 and only reached the colon's inner layer. "That was a very big deal to me—the fact that it shrank the tumor as much as it did," Dale says. Without that upfront treatment, a permanent colostomy likely would have been required, Thomas says.

This summer, Dale returned to the operating room to reverse his temporary colostomy. At this point, there's no evidence of cancer, Thomas says. "This is curative treatment," she says, adding that Dale will be monitored closely for signs of recurrence.

Streamlining Care

At Ocean Medical Center, a 281-bed hospital in Brick, New Jersey, the twice-monthly lung cancer meeting can include as many as a dozen people sitting around the table, including a clinical research nurse and a cancer registrar, says Joyce Cline-Blasi, RN, who serves as the program's nurse navigator. In her navigator role, Cline-Blasi not only helps coordinate the treatment itself, but also strives to connect patients with support groups and follows them during outpatient treatment.

Closely coordinated care, with the help of a navigator, can shorten the window between diagnosis and beginning treatment by more quickly gathering imaging tests and other data that the tumor board will require, says Frank Vicini, MD, chief of oncology services at Beaumont Hospital in Royal Oak, Michigan. For example, better coordination of lung cancer treatment at Beaumont—fast-tracking patients from that first worrisome scan—has reduced the time to treatment lag from two to three months to just a week or two, he says.

Psychological support also is part of multidisciplinary care. As part of his

treatment, Dale received several months of counseling. Given his young age at diagnosis, he also underwent genetic testing—it didn't reveal any markers—to identify any potential family risk.

Pulling together and coordinating all of these clinical components, though, can be particularly challenging for physicians in private practice, says Boccia, the community oncologist, sounding a bit discouraged after a long day of seeing patients. Cancer patients in the U.S., he points out, face a growing shortage of oncologists that will only further strain physician time in the years ahead. A shortfall of 2,550 to 4,080 oncologists nationally is projected by 2020, according to an analysis commissioned by the American Society of Clinical Oncology.

Some days, Boccia's calendar is filled with as many as 30 patient appointments. If he worked as part of a multidisciplinary program, with the attendant coordination and time commitments, he estimates that he might only be able to schedule 10 patients each day.

Reaching All Patients

For Steve Kelley, a tumor board's involvement was a significant plus when he started researching his treatment options in the fall of 2006. The 40-year-old Californian, who had never smoked, was reeling from his diagnosis with stage 3 non-small cell lung cancer. And he wasn't necessarily impressed by the first oncologist he met.

Then he got an appointment at Hoag Cancer Center, located in his home community of Newport Beach. He liked the physicians involved, as well as their close teamwork. "You like to think that you've chosen the right doctors," he says. "But it's always nice to know they've discussed it (treatment) with their colleagues."

Just as valuable as discussing individual patients, if not more so, is the educational component of multidisciplinary care, says Robert Dillman, MD, executive medical and scientific director at Hoag Cancer Center, part of Hoag Hospital. "It's very easy for physicians to slip into doing the same things over and over again and to not realize how things have changed."

Dillman touts Hoag's success as an illustration of what a community cancer center can accomplish with multidisciplinary care, at least in a large urban area like Orange County. An analysis of five-year survival rates, conducted before and after the center initiated comprehensive treatment, identified a survival increase—from 63 percent (1986 to 1991) to 71 percent (1992 to 1999). Survival also increased for 22 of the 24 malignancies analyzed, according to the study, published in 2005 in the *Journal of Oncology Practice*.

Kelley is one of the center's success stories. He soldiered through a rough year, holding down a job in corporate finance while he underwent chemotherapy and then lung surgery, followed by more chemotherapy and six weeks of radiation. "We wanted to be very aggressive," he says. Nearly three years after his diagnosis, his imaging scans remain clear.

But not all Hoag patients receive a tumor board evaluation. Roughly one-third of

the 2,400 newly diagnosed patients last year were discussed in a tumor board setting, Dillman says. Ideally, every patient's care would be reviewed by a tumor board, he says. Vicini, of Beaumont Hospital, makes a similar point, saying logistics and the number of staff make reviewing every case currently infeasible at his facility. "But that's my goal," he says. "You don't want two standards of care—you can't."

To read the full report of the CURE Rare Cancer Survey, sponsored by Novartis Oncology, go to www.curetoday.com/rare_cancer_survey.