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The central urology multidisciplinary team – is it time to change the referral criteria? An audit of practice in a district general hospital in London

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ABSTRACT

INTRODUCTION All cancer patients are discussed in multidisciplinary team meetings (MDTs). Certain patients are referred to the Central MDT based on specific national criteria. We wanted to see whether the Central MDT aided in the decision-making process above that of the Local MDT alone.

PATIENTS AND METHODS All MDT forms (local and central) for 2007 were retrospectively reviewed.

RESULTS A total of 217 patients were reviewed at the Local MDT. Of these 217 cases, 102 (47.0%) cases were referred to the Central MDT and 15 of the 102 (14.7%) cases were awaiting investigations at the time of the Local MDT and were, therefore, excluded. For the prostate cancer cases (n = 67), the Central MDT did not change outright the Local MDT decision in any case, but in 6 of 67 (9.0%), advised/excluded patients from clinical trials. For bladder cancer cases (n = 19), 4 of 19 (21.0%) patients had their management changed by the Central MDT. The one kidney cancer case had its Local MDT decision changed by the Central MDT.

CONCLUSIONS This audit suggests that the Central MDT plays a useful role in the decision-making process for bladder and kidney cancers, and helps determine eligibility for clinical trials in metastatic prostate cancer patients. Its value over the Local MDT alone in the decision-making process for non-metastatic prostate cancer is questionable.

KEYWORDS
Multidisciplinary team – MDT – Audit – Arology

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Introduction

In order to improve outcomes of all cancers, the UK National Institute for Health and Clinical Excellence (NICE) encourages the management of all cancer patients by specialty-specific multidisciplinary teams (MDTs) composed of designated specialists from various disciplines including surgeons, pathologists, radiologists, and oncologists. For urological oncology, this is detailed in the document *Improving Outcomes in Urological Cancers*.[1] This document encourages regular MDT meetings in the local hospital (the so-called Local MDT) where relevant information on all cancer cases is reviewed by the panel and collective decisions regarding management are made. As a safeguard to ensure best practice, a further MDT that is central to the Strategic Health Authority region (the so-called Central MDT) reviews all local (hospital) MDT decisions for certain cancer patients based on well-defined referral criteria. The Central MDT is composed again of members from different specialties, but those with a special interest in uro-oncology working in a tertiary, specialist centre.

The criteria for referral of uro-oncological cases from the Local MDT to the Central MDT are: (i) T1–T3 M0 N0/Nx prostate cancer in patients with a life-expectancy ≥ 10 years); (ii) G3/CIS/muscle-invasive/metastatic/failed BCG bladder cancer; (iii) complex renal cancer patients (genetic disorder, solitary kidney, lymph node metastases, invasion of local organs, renal vein/IVC thrombus, or metastases); and (iv) those for consideration of partial nephrectomy/cryoablation, and renal tumours < 4 cm.[1]

Although it might appear intuitive that a Central MDT composed of experts in the field might safeguard against poor decision-making at the Local MDT, there is no published data to address whether it is truly necessary for each of the referral criteria specified. For instance, should the Local MDTs make similar decisions to the Central MDT for

a particular referral criterion, then it might not be an optimal use of resources for such cases to be discussed at the Central MDT.

In this audit, we aimed to investigate whether the Central MDT based at the Royal Marsden Hospital, London, aided in the decision-making process of our urological cancer cases from our medium-sized district general hospital, Kingston Hospital, Kingston upon Thames, Surrey.

Patients and Methods

During each case discussion at both the Local MDT (Kingston) and Central MDT (Royal Marsden), an MDT form is filled out with the case details including presenting symptoms, diagnosis, relevant histology and radiology, patient co-morbidities, and management plan. We retrospectively collected and reviewed all MDT forms (Local and Central) for a 1-year period from 1 January 2007 to 31 December 2007. The Local MDT management plans were compared with the Central MDT decisions.

All data were collected and reviewed by the lead author (PS) alone. A total of 217 patients were discussed at the Local MDT in the time period studied. Of these cases, 102 (47.0%) were referred to the Central MDT as per the criteria outlined above. Fifteen of these 102 (14.7%) cases did not have their investigations completed at the time of Local MDT review and thus no definite Local MDT decision was made prior to Central MDT referral. These cases were, therefore, excluded. A total of 87 cases were thus reviewed; in all cases, the MDT forms were obtained and both Local and Central MDT decisions were noted, *i.e.* no cases were lost due to poor documentation.

Results

Overall, 67 of 87 (77.0%) cases had T1–T3 M0 N0/Nx prostate cancer with a life expectancy ≥ 10 years. In none of these cases did the Central MDT change outright the management decision of the Local MDT. However, in 4 of 67 (6.0%) cases, the Central MDT also advised that the patient be offered the option of entering a clinical trial which was not mentioned in the Local MDT plan; in 2 of 67 (3.0%) cases, the Central MDT excluded patients from clinical trials proposed by the Local MDT. In 4 of 67 (6.0%) cases, the Central MDT altered the choice of further investigations though in none of these cases did the management decision change. In 11 of 67 (16.4%) cases, the histological Gleason grade was amended by the Central MDT pathologist, with 8 of 11 (72.7%) cases being upgraded and 3 of 11 (27.3%) cases being downgraded. However, the Central MDT did not change the Local MDT decision in any of the cases in which the histological grade was amended.

Of the 19 of 87 (21.8%) patients with bladder cancer, 3 of 19 (15.8%) who had G3pT2 disease and 1 of 19 (5.3%) with G3pT1b+CIS had their management altered by the Central MDT. In the first case with G3pT2, the Local MDT decision was for radical cystectomy and ileal conduit alone, whereas the Central MDT decided on neo-adjuvant chemotherapy prior to radical surgery. In the second case with G3pT2, the decision was changed from re-look transurethral resection of bladder tumour (Local MDT) to neo-adjuvant chemotherapy plus radical surgery/radiotherapy, or entry into the SPARE trial comparing neo-adjuvant chemotherapy plus surgery to neo-adjuvant chemotherapy plus radiotherapy (Central MDT). The final case with G3pT2 had radiotherapy advised by the Local MDT but the Central MDT suggested neo-adjuvant chemotherapy followed by either cystectomy or radiotherapy depending on response. The one case with G3pT1b+CIS was advised simply a check cystoscopy by the Local MDT in light of the patient's age (86 years), but the Central MDT felt that, in spite of this, the patient should have a 6-week trial of BCG.

The final case referred to Central MDT was of a 3.5-cm solid renal mass in an 80-year-old. The Local MDT decided on radiofrequency ablation but the Central MDT advised surveillance with imaging.

Discussion

The role of the MDT in cancer management has been widely advocated. However, other authors have shown that it rarely alters the primary decision of the treating clinician.[2] Nevertheless, the MDT provides a safeguard against maverick clinicians, with a round-table consensus being reached for every cancer case. The second tier of MDT, the Central or Specialist MDT, requires that certain cases are discussed in a tertiary setting based on strict referral criteria. The evidence behind how these criteria were defined is lacking, and there is no previously published data we are aware of that considers whether the Central MDT adds anything to the management plan of the Local MDT.

In our district general hospital there is no radical cancer surgery, radiotherapy, or chemotherapy, services for which patients are sent to the specialist centre (Royal Marsden Hospital). This specialist centre, therefore, reviews all cases referred to it according to certain criteria. Our audit shows that the vast majority (77.0%) of referrals to the Central MDT are for localised prostate cancer in men with ≥ 10-year life expectancies. In these cases, the management decision was never altered; however, in almost one in ten cases (9%), trial eligibility was altered by the Central MDT. This perhaps suggests that, if Local MDTs were better informed regarding appropriate clinical trials for their prostate cancer patients, the vast majority of referral to the Central MDT could be avoided, with considerable resource savings.

This audit also found that 16.4% of prostate cancer cases had their histological grade changed by the Central MDT

pathologist. This figure is in keeping with other studies[3] and supports the need for a quality assurance scheme for district general hospital pathologists reporting Gleason scores.

Over 20% of bladder cancer cases referred to the Central MDT had their management altered, most notably in terms of offering non-surgical (oncological) options. The one case with renal cancer also had his management changed by the Central MDT. This suggests that the Central MDT is a valuable resource for the less common urological cancers.

The major limitation of this audit is that it looks at practice in one district general hospital and its referring central teaching hospital only. This practice may, therefore, not be representative of other institutions throughout the UK, or indeed, throughout the rest of London. However, it is likely to represent 'best current practice' given that the central teaching hospital is one of the foremost cancer hospitals in the UK. The fact that no patient with localised prostate cancer had his management altered by the Central MDT, which offers all radical and surveillance options for such patients, suggests that, at least in the catchment area of the local hospital investigated, the need to discuss every such patient in a Central setting is questionable.

Conclusions

The Central MDT appears of value in the less common urological cancers, but of limited use in deciding the management of patients with localised prostate cancer and ≥ 10-year life expectancies. Dissemination of clinical trial eligibility criteria to the Local MDT would mean that no such case would benefit from referral to the Central MDT and, thus, would warrant dropping this referral criterion. This would potentially save significant costs for a rationed National Health Service.

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