Oncoplastic multidisciplinary meetings: a necessity or luxury?

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ABSTRACT

Although there is scant evidence to support multidisciplinary meetings in any cancer specialty, they are now regarded as best practice. We believe the oncoplastic multidisciplinary meeting plays a similarly important role, consolidating oncoplastic multidisciplinary working and allowing transparent decision making, standardisation of care and recording of results. This may drive oncoplastic surgery to an evidence-based position from which oncoplastic excellence can be achieved.

KEYWORDS

Oncoplastic – Breast cancer – Multidisciplinary team – Multidisciplinary meeting

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Multidisciplinary teamworking is well established in the management of most cancers and is associated with improved outcomes and patient experience.¹ For breast cancer, the multidisciplinary team (MDT) meeting is the focus of the week, allowing correlation of clinical, imaging and pathology results and the formation of a cohesive management plan.

The aim of oncoplastic breast surgery is to deliver optimal oncological surgery combined with a range of techniques to limit the aesthetic impact of breast conservation or mastectomy. Oncoplastic surgery has equivalent survival and local recurrence rates to standard breast conservation techniques.² Although oncological control remains the primary goal, improved five-year survival rates increase the emphasis on long-term aesthetic results.

Oncoplastic techniques are varied and choosing the approach most likely to give the best outcome can be complex. Decisions are based on detailed pre-treatment assessment of patient and tumour variables such as disease location and extent, ratio of tumour to breast volume and the potential impact of anticipated adjuvant treatments, particularly radiotherapy, which has a detrimental impact on breast reconstruction. If patients are to have access to the full range of oncoplastic techniques, collaborative working between breast and plastic surgeons is essential. It is not possible for any one surgeon or discipline to acquire and maintain all the skills and expertise.

Cancer multidisciplinary teamworking developed in the 1990s after the Calman–Hine report on cancer care in the UK found access to care was non-uniform, referral was disjointed and treatment was variable.³ Similar criticisms are made of oncoplastic surgery today, with variability of access,

lack of transparent decision making and weakly reported outcomes. Questions around ‘added value’ are compounded by increasing financial constraints. The National Mastectomy and Breast Reconstruction Audit was set up to assess some of these issues and it provides some useful quality outcome measures.⁴

The 1998 European Breast Cancer Conference consensus⁵ and the 2007 guidelines from the British Association of Plastic, Reconstructive and Aesthetic Surgeons and the Association of Breast Surgery⁶ both emphasise the multidisciplinary nature of care. We believe that closer collaboration can be achieved through oncoplastic MDT meetings, maximising utilisation of available expertise, strengthening teamworking and facilitating progression towards high-quality, seamless oncoplastic care.

Oncoplastic MDT meetings

Our first oncoplastic MDT meeting took place in 2007. We now meet fortnightly with video-linking across two sites. The oncoplastic team comprises seven consultant surgeons (four oncoplastic, three plastic), breast care nurses and ten surgical trainees. Attendance is optional but remains excellent. The senior oncoplastic fellow acts as meeting coordinator to collate and present cases including a brief history, co-morbidities, patient preferences, oncological recommendations, examination findings (aesthetic and oncological) and standardised photographic views.

Our oncoplastic unit is part of a specialist cancer centre. In 2008 we operated on approximately 600 new breast cancers including 50 oncoplastic breast-conserving procedures and 250 breast reconstructions (immediate and delayed) of

which 90 were free flaps. Approximately ten patients are discussed at each meeting, in particular those for consideration for free flap reconstruction or complex revision surgery and second opinions. We also review significant complications and cases that illustrate a learning point. Patients requiring highly specialised intervention can be allocated according to expertise. The oncoplastic MDT meeting has allowed lively but open discussion, consensus gathering and shared decision making. This is of particular value in providing a realistic assessment of what is achievable and has enabled us to manage patient expectations while offering consistent advice. The meeting consensus is recorded in the electronic patient record.

Adding another MDT meeting to the working week could be criticised as it decreases time available for more quantifiable activity. Attendees rate the interdisciplinary and cross-generational educational experience highly but improvements in team education are difficult to measure. Anecdotally, we feel collaborative working enriches our experience, reflecting the perception from other disciplines that multidisciplinary working is good for morale. Senior members have found the stronger team identity useful in operational and strategic meetings with the hospital executive. Other benefits of the meeting include streamlining of the patient pathway, development of procedure-specific consent forms and standardisation of eight photographic views that are accessible in a secure web-based archive.

We do not have any objective data to demonstrate the effectiveness or impact of the oncoplastic meeting on patient outcomes as it is difficult to gain objective measures of oncoplastic outcomes due to the many, highly individual variables that need to be taken into account, influenced by patient expectation. We await the details of the National Mastectomy and Breast Reconstruction Audit⁴ to see how our outcomes (as reported by patients) compare with national practice but it will not be possible directly to attribute any results to the oncoplastic MDT meeting. Randomised trials have not, to date, been used to assess oncoplastic interventions although a trial of breast reconstruction is currently recruiting. Multidisciplinary working does increase trial recruitment and could help oncoplastic surgery develop rigorous outcome measures and recognised standards.

Conclusions

Although there is scant evidence to support the value of MDT meetings in any cancer specialty they are now regarded as best practice. We believe the oncoplastic MDT meeting plays a similarly important role, consolidating oncoplastic multidisciplinary working and allowing transparent decision making, standardisation of care and recording of results. This may drive oncoplastic surgery to an evidence-based position from which oncoplastic excellence can be achieved.

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