

Cancer Management is a Multidisciplinary Team Work

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Cancer incidence is rising across the world. Up-to-date statistics on cancer occurrence and outcome are essential for the planning and evaluation of programmes for cancer control. In Pakistan we do not have a National Cancer Registry. Data is being published on the South Karachi cancer cases. The age-standardized rates (ASR) for cancer (whole body sites), during 1995 to 1997 in Karachi South were 139.11/100,000 in males and 169.5/100,000 in females. Corresponding rates for the period 1998 to 2002 were 179.0/100,000 in males and 204.1/100,000 in females. In the 1995-1997 data, the most common malignancies (ASR per 100,000) in males were lung (21.3), oral cavity (14.2), urinary bladder (9.0), and larynx (8.8). The most frequent cancers in females were breast (53.1%), oral cavity (14.5%), and ovary (10.9%). The data from 1998 to 2002 showed a rising incidence for lung (25.5%), larynx (11.8%), and urinary bladder (9.9%) in males and breast (69.1%), esophagus (8.6%), and cervix (8.6%) in females. The mean age of cancer all sites was 51.2 years (95% CI 49.4-53.1) for males; 50.0 years (95% CI 48.2-52.4) for females in 1995-1997. Corresponding rates for 1998-2002 were 49.5 years (95%CI 47.5-51.4) in males and 53.7 years (95% CI 51.5-55.6) in females.¹ Some institutions are now starting to develop their own Cancer Registry.

The global cancer incidence estimate by the GLOBOCAN 2002 was 8.7% (men 13.3%; women 3.4%) underestimated due to under-ascertainment in elderly cases. This means that worldwide, new cancer cases in 2002 were 11,810,000 (6,574,000 men; 5,236,000 women), overtaking the original estimate by 1 million.²

The crude annual incidence of cancer in Europe has been estimated at 338 per 100,000 population for Eastern Europe and 447 per 100,000 population in Western Europe.³ Each year more than 284,000 people are diagnosed with cancer (excluding non-melanoma skin cancer) in the UK, and more than 1 in 3 people will develop some form of cancer during their lifetime.⁴

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Received October 26, 2010; accepted March 4, 2011.

In Europe, the relevant information for 2008 is not generally available as yet, therefore, statistical models based on published data were used to estimate incidence and mortality data for 25 cancers in 40 European countries (grouped and individually) in 2008. If not collected, national rates were estimated from national mortality data and incidence and mortality data provided by local cancer registries of the same or neighbouring country. There were an estimated 3.2 million new cases of cancer and 1.7 million deaths from cancer in 2008.⁵

Despite the lack of a Registry and population-based data on demographics and characteristics of various cancers, this fact is being observed by practicing clinicians that now they are diagnosing more malignancies in their clinics than ever before. One of the typical prototype example is squamous cell carcinoma of the head and neck region which is found to be associated with the use of tobacco in the form of beetle leaf, beetle nuts, various forms of chewing tobaccos, *gutkas* and a combination of some or all of these harmful substances.

As rising cancer incidence is a global issue, and some cancers are preventable, health policy makers in certain countries took the issue as a national priority. Countries like USA, UK, France, and others had made their National Cancer Plans, and they are in the process of implementing their goals and objectives.

We in Pakistan are still struggling to develop these strategies. Being a developing country we cannot afford to provide state-of-the-art treatment facilities to the patients. The overall expenses of cancer management are huge and lack of resources is a major factor, which plays a vitally important role in the poor outcome of this disease in our country. Patients present late, and by the time their tumours are diagnosed, they can only be considered for palliative treatment.

With the above mentioned suboptimal starting point, there is another issue of treatment. Other countries of the world had learnt the hard lessons and now they have realized that cancer management is not a one man show. It is of the highest importance and relevance to involve key stake holders in the form of all concerned specialties before embarking on a comprehensive management plan for a particular patient. Working in a world where the working week and the available qualified staff are both shrinking, a continuous provision of good quality care and clinical services is only possible with multidisciplinary team work.

Being looked after by a multidisciplinary team, the patient's faith and confidence increases markedly just as an assurance of not being treated by a single clinician.

The UK Cancer Plan set out the first comprehensive national cancer programme for England. It had four aims, which were centered around tackling health inequalities in order to get down the death toll of the unskilled workers, who were twice as likely to die of cancer as compared to the professionals. They invested into strong cancer research and genetics, to save more lives, ensuring provision of the best available support, care and treatment to all the cancer patients. This plan provided a strategy for bringing together prevention, screening, diagnosis, treatment and care for cancer and the investment needed to deliver these services in terms of improved staffing, equipment, drugs, treatments and information systems.⁶

There is a growing tendency amongst members of the oncology community to form Expert Panel Multi Disciplinary Tumour Boards and to discuss all cases in this panel before offering the treatment to the patient. As this is a recommended international approach, specialists are quite willing to adopt this culture of sharing ideas with their colleagues. An evidence of multidisciplinary approaches providing optimal treatment outcome for locally advanced head and neck cancer, with overall survival in these patients being comparable to that reported in randomized clinical trials was reported by Nguyen *et al.* in their retrospective analysis of 213 patients treated for locally advanced head and neck cancer in a single institution.⁷ This effective clinical approach will provide opportunities to individual members of the team to speak directly to each other about clinical matters, discussing the often forgotten clinical management protocols, thus enhancing their quality of care and outcome.

Unfortunately, no institute so far, has made arrangement to discuss all newly diagnosed cancer patients in their Tumour Boards. In my opinion, no cancer patient should be treated without making a comprehensive management plan which has to be agreed upon by consensus in an Expert Panel Multi-Disciplinary Tumour Board. The core constituents of a Tumour Board are Oncologists, Surgeons, Radiologists, Pathologists and Physicians. Other members from the support services can also participate e.g. Nutritionists, etc. Postgraduate trainee doctors can learn and develop valuable clinical skills while attending the Boards. This is an easy access to knowledge, where case discussions lead to a cross fertilisation of ideas that may not have been apparent to a single treating clinician. Team working increases the sense of partnership and provides friendship and support particularly in difficult clinical situations such as

the management of clinical errors and complaints. An effective arguing for resource management can duly be addressed.

It is high time for all the Pakistani specialists involved in the care and management of cancer patients to come forward and establish these boards both in private and public sector hospitals.

Hopefully, we would go through the same flux, and after initial teething problems, non-oncology colleagues can be convinced to come forward and help in the formation of these team meetings, which can be conducted on a regular basis with a view of discussing all the newly diagnosed cases of cancer.

Keeping the above mentioned facts in view, some consultant colleagues across the country are trying to spare their times from busy academic and clinical commitments for the Tumour Boards but more comprehensive and generalized efforts are required in order to achieve a 100% coverage. All teaching hospitals in Pakistan have the vision of establishing these tumour boards in their institutes. Some have already started and some are in the process of establishing them. The Aga Khan University Hospital, Karachi, is a tertiary referral teaching hospital where a Friday morning weekly tumour board is taking place since last many years. Specialist colleagues from almost all major hospitals in Karachi attend this tumour board and present and give their independent expert opinions on complex cancer cases. Site-specific tumour boards, e.g. Breast, Head and Neck, Orthopaedics, Gynaecology, Paediatrics, Thyroid, etc. are being established as well. The final outcome is documented in the patients' case notes. During the Board meetings postgraduate trainees present the cases and according to our experience, that serves as the best form of their structured training as they openly discuss cases and learn how to tackle difference of opinion. Multi-disciplinary presence gives a sense of team ownership of the cancer patients. At this point it is important to clarify that cases of other hospitals are also welcomed here and our colleagues working elsewhere are also given the opportunity to present and discuss their cases. These mutual sessions have lead to fruitful decisions, benefiting patients and saving cost and time.

Such tumour boards have also been started at some other public hospitals but the need is to spread the practice to encompass the whole spectrum of new cancer cases as much as possible.

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