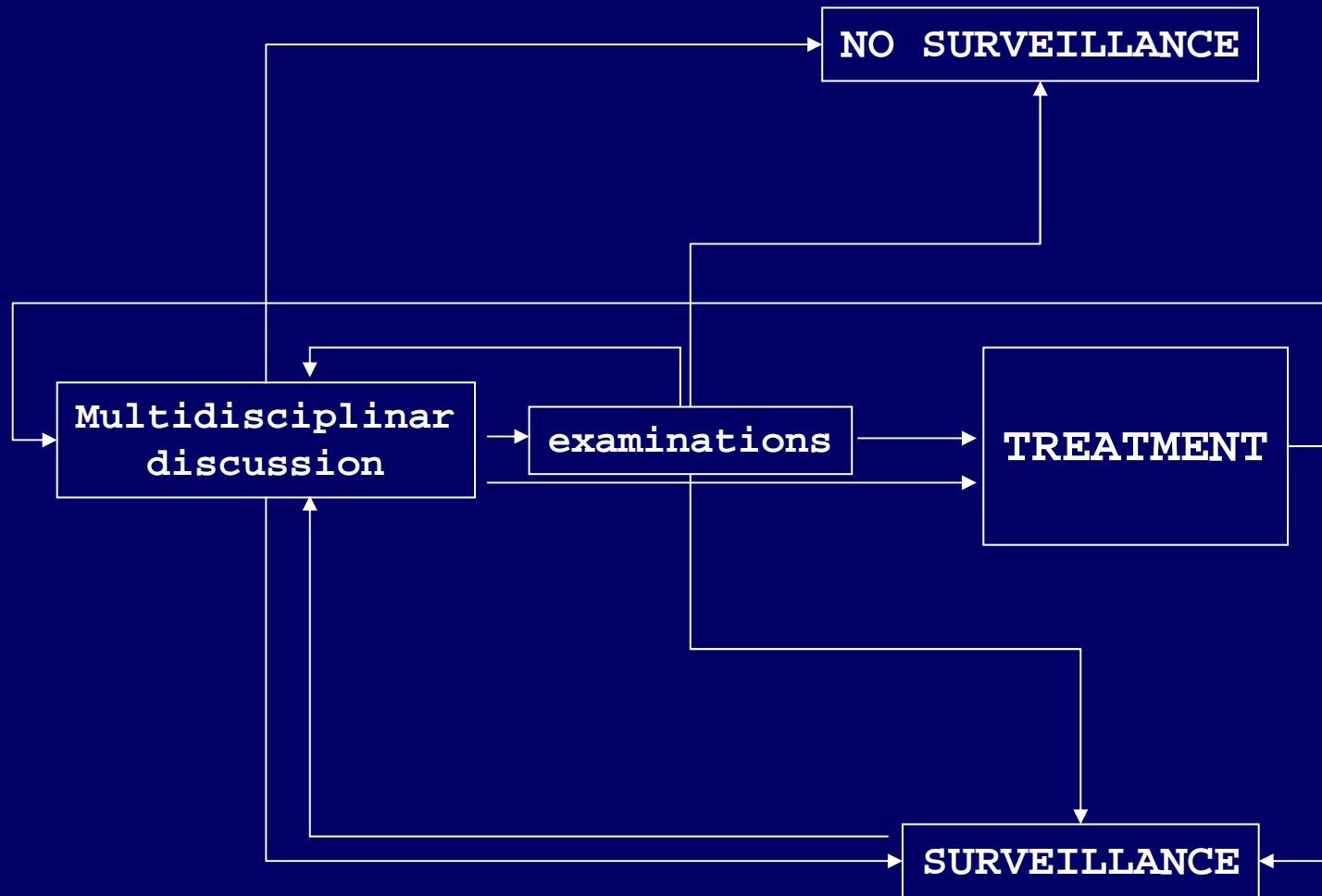


**BILAN D'UN AN
D'ACTIVITE DU GOThA**

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&

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THE PARADOXE OF MULTIDISCIPLINARITY IN LUNG CANCER

"State-of-the-art care often requires input from many sources, including pulmonology, thoracic surgery, medical oncology, radiation oncology, pathology, and radiology.

As a result, multidisciplinary input into care is vital."

WM Alberts, ACCP guidelines, Chest 2003; 123: 332S-337S

On March 2005, no prospective data on multidisciplinary management of lung cancer was available on Medline.

WHY MULTIDISCIPLINAR IS BETTER ?

1. THE STAGING

“Considering the 2.377 cases with clinical and pathological staging data, a classification coincidence was observed in 1.108 cases (47%)”.

A Lopez-Encuentra, *Annals of Thoracic Surgery*, 2005; 79: 974-979

DO WE STAGE GOOD ?

WHY MULTIDISCIPLINAR IS BETTER ?

cTNM & pTNM. THE LEVEL OF AGREEMENT

| | |
|----|-----|
| T3 | 53% |
| T4 | 18% |
| N0 | 89% |
| N1 | nil |
| N2 | 8% |

THE ROLE OF SURGICAL STAGING

WHY MULTIDISCIPLINAR IS BETTER ?

2. THE TREATMENT

"Treatment **recommendations** should be based on locally agreed-on adaptations of clinical practice guidelines."

WM Alberts, ACCP guidelines, Chest 2003; 123: 332S-337S

ARE THESE RECOMMENDATIONS FOLLOWED ?

WHY MULTIDISCIPLINAR IS BETTER ?

3. THE FOLLOW-UP

"The surveillance program should be coordinated by a multidisciplinary tumor board."

GL Colice, ACCP guidelines, Chest 2003; 123: 272S-283S

WHAT ABOUT PATIENTS SURVIVAL ?

STUDY DESIGN

Study type: prospective, observational

Inclusion: lung cancer cases discussed by the G0ThA for the first time starting on June, 1 2003

Endpoints:

1. CONCORDANCE OF TREATMENT
2. Delay of treatment
3. Rate of invasive staging
4. 1 year actuarial survival

Funding: Chugai Pharma, Paris

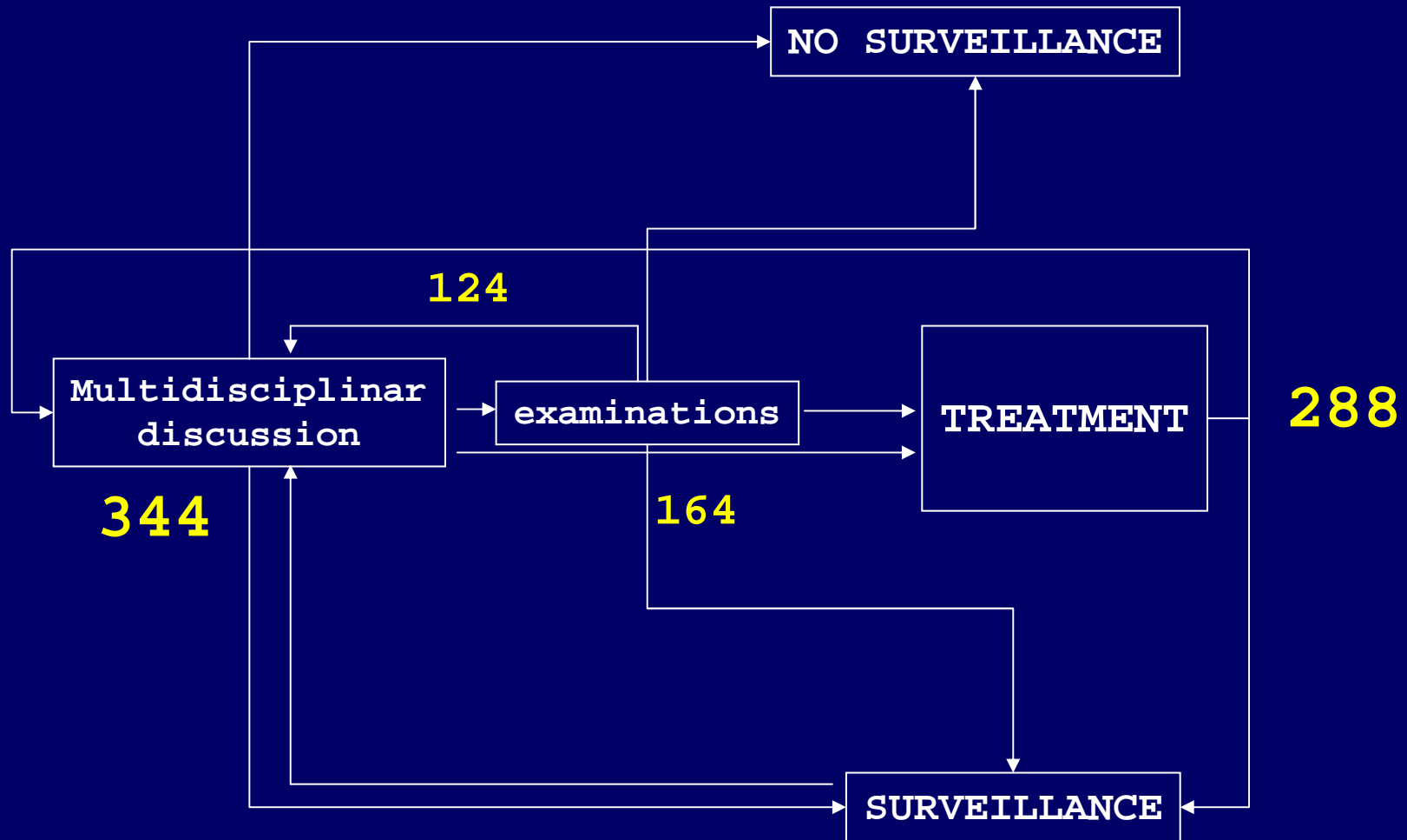
STUDY POPULATION

| | | |
|----------------------------------|------------|--------------|
| Population | 344 | |
| Males | 251 | 72.9% |
| Age | 67 | |
| Diagnosed lung cancer | 247 | 71.8% |
| Stage I | 48 | 13.9% |
| Stage II | 41 | 11.9% |
| Stage III | 150 | 43.6% |
| Stage IV | 105 | 30.5% |

REASON OF DISCUSSION

| | | |
|---------------------------------|------------|---------------|
| Diagnosis | 77 | 22.4 % |
| First treatment | 155 | 45.1 % |
| II or more treatment | 28 | 8.1 % |
| Adjuvant treatment | 40 | 11.6 % |
| Follow-up | 44 | 12.8 % |

TREATMENT RECOMMENDATIONS



THERAPEUTIC DECISION

| TREATMENT | REASON OF PRESENTATION | | | | |
|---------------------------|------------------------|-------------|----------------------|----------|-----------|
| | diagnosis | I treatment | II or more treatment | adjuvant | follow-up |
| Surgery | 17 | 52 | 4 | - | 5 |
| Chemotherapy | 0 | 86 | 35 | 28 | 5 |
| Radiotherapy | 0 | 5 | 4 | 1 | 2 |
| Chemo-radiotherapy | 0 | 25 | 1 | 7 | 2 |
| Supportive care | 1 | 7 | 1 | 0 | 1 |
| Examinations or follow-up | 56 | 40 | 2 | 12 | 29 |

INVASIVE STAGING

(surgical staging procedure before
therapeutical decision)

29 %

(36/124 patients)

| | |
|----------------------|----|
| Videomediastinoscopy | 24 |
| Videothoracoscopy | 5 |
| Combined VM / VT | 3 |
| Other | 4 |

DISCORDANCE OF TREATMENT

4.5%

13 / 288 patients

DISCORDANT CASES

(n=13)

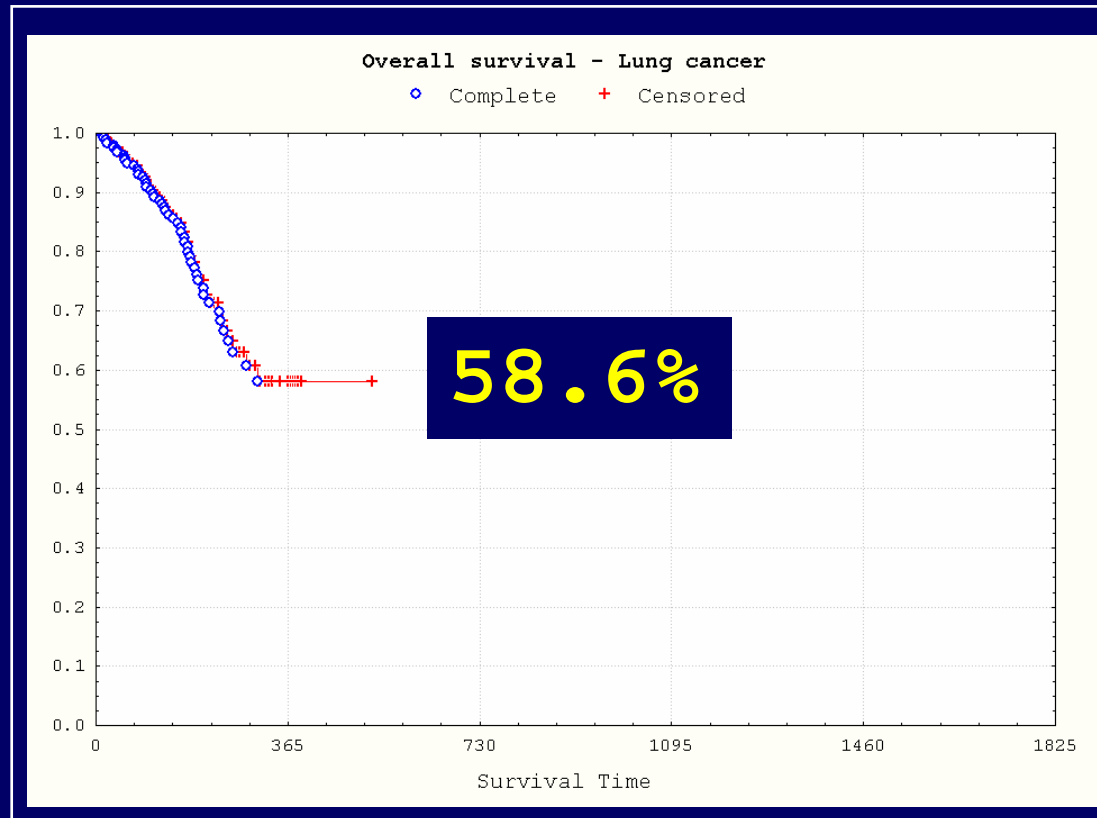
| Sex | Age | Decision | Reason of discordance |
|-----|-----|-----------------|-------------------------------------|
| F | 72 | Surgery | M+ discovered at PET scan |
| H | 71 | Supportive care | Lost |
| H | 78 | Chemotherapy | Patient refusal |
| F | 81 | Radiotherapy | Rt contraindicated (respiratory fx) |
| H | 83 | Surgery | Lost |
| H | 78 | Radiotherapy | Poor general status |
| H | 82 | Supportive care | Radiotherapy > deceased |
| H | 88 | Surgery | Poor performance status |
| H | 73 | Chemotherapy | Patient's refusal |
| H | 75 | Chemotherapy | Patient's refusal |
| F | 78 | Radiotherapy | Patient's refusal |
| M | 50 | Surgery | Patient's refusal |
| F | 57 | Chemotherapy | Patient's refusal |

DELAY OF TREATMENT

24.9 days

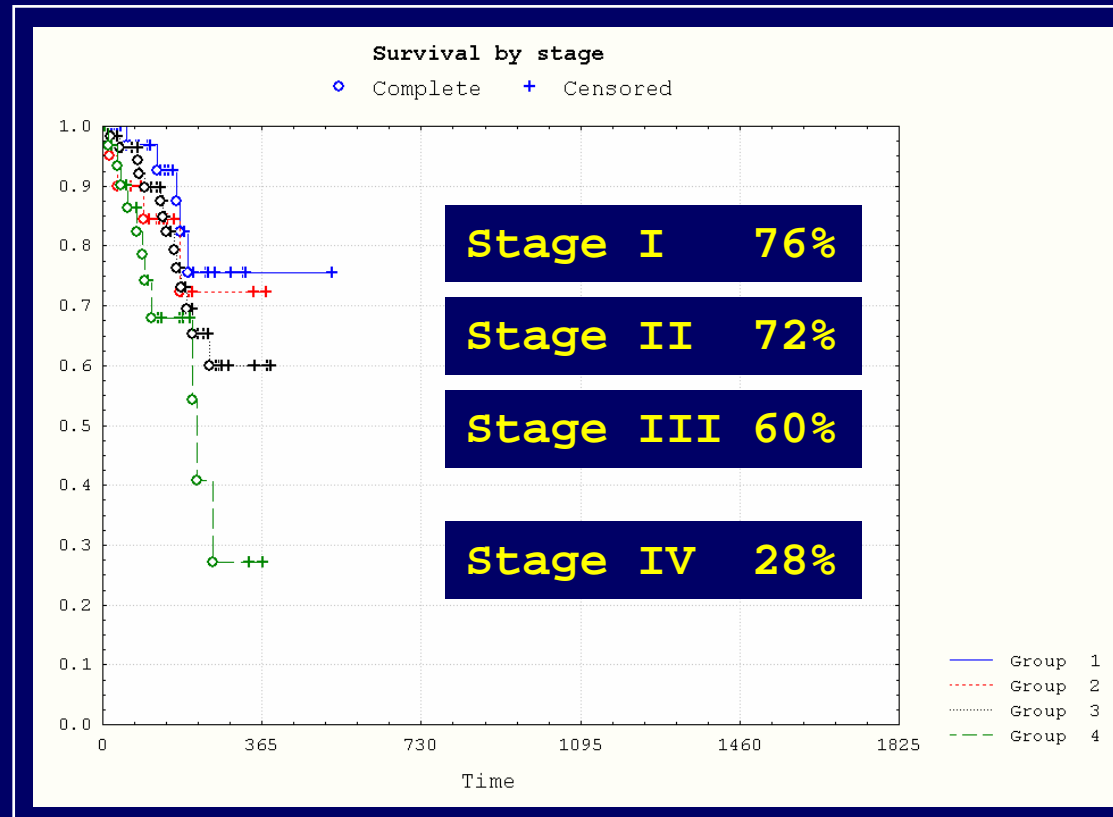
| | |
|--------------|-----------|
| Surgery | 28.4 days |
| Chemotherapy | 24.5 days |
| Radiotherapy | 35.5 days |

OVERALL SURVIVAL



RECORDED DEATHS 61, CANCER-RELATED DEATHS 57, MEAN FOLLOW-UP 152.6 DAYS

SURVIVAL BY STAGE



LUNG CANCER

"Overall, the present report only superficially addresses the important issue of multidisciplinary management of lung cancer patients".

"A treatment delay of 4 weeks is too long and suggests, at least in my opinion, inefficient management of patients".



CHEST

"In the final analysis this is a summary of what this team saw over several years and adds nothing to the literature about the efficacy of multidisciplinary evaluation. There was not even an attempt to compare to concurrent or historical groups let alone a randomized comparison"

CONCLUSIONS I

The GOTHa is actually the only multidisciplinary team who developed a prospective strategy of quality assessment.

Collected data represent a baseline for further GOTHa quality evaluation.

In absence of term of comparison, we assume a discordance rate $\leq 5\%$ as acceptable.

CONCLUSIONS II

Feedback information are crucial to assess quality of a multidisciplinary team.

A dedicated person is required for data collection and verification.

The database should be as simple as possible.

The development of an alphanumeric coding system is needed to deal with a large amount of data and to exchange data with other multidisciplinary teams.